Hawthorn Drive Surgery

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Hawthorn Drive Surgery on 14 November 2016. Improvements were required and a warning notice was served in relation to ensuring processes were in place for effective governance. The practice was rated as inadequate and was placed in special measures. The full comprehensive report on the November 2016 inspection can be found by selecting the 'all reports' link for Hawthorn Drive Surgery on our website at www.cqc.org.uk.

We undertook a focused follow up inspection on 16 February 2017 to check that the practice had taken urgent action to ensure they met the the required improvements for good governance. This report only

Summary of findings

covers our findings in relation to the warning notice. A comprehensive inspection will be carried out within six months to check that the practice had followed their action plan for the other issues identified at the previous inspection and to confirm they meet legal requirements.

Our key findings were as follows:

- There was an effective system for recording and reporting of significant events. A process for sharing of learning and ensuring that actions had been completed had been established, but needed to be embedded into practice. This was the same for complaints.
- Clinical staff had signed up to received Medicines & Healthcare products Regulatory Agency (MHRA) alerts and National Institute for Health and Care Excellence (NICE) guidance. These were shared within the practice. A process had been established to review and act on MHRA alerts. Some alerts from 2016 had been acted upon but two which had been identified by the practice as relevant had not yet been acted upon.
- Multi-disciplinary meetings had been scheduled and one meeting had taken place. Patient records had been updated to reflect the discussion and agreed actions.
- The practice had established an agreed coding system for patients' conditions and care and treatment needs. Improvements had been made to ensure patients were coded according to their diagnosis and that treatment was appropriate. However we found two examples of where patients had been coded inaccurately.
- A system of recall for patients who required monitoring had been established which include a lead GP, nurse and administration support and was due to be implemented imminently.
- A foundation for effective governance had been established. This included lead roles for GPs and lead clinical areas for GPs, nurses and administration staff. A range of meetings had also been established, scheduled and at least one meeting had occurred, which had been minuted.

However, there were areas where the provider needed to continue to make improvements.

Importantly, the provider must:

- Ensure that Medicines & Healthcare Regulatory Agency (MHRA) alerts identified as needing to be actioned are completed and the changes affected to ensure patients are safe and an effective process for checking that National Institute for Health and Care Excellence (NICE) guidance has been implemented appropriately.
- Continue to maximise the functionality of the computer system in order that the practice can run clinical searches, provide assurance around patient recall systems, consistently code patient groups and produce accurate performance data.
- Ensure that annual health reviews are offered for those patients with a learning disability who have not yet received one and that coding for patients with a learning disability is accurate.

The areas where the provider should make improvements are:

- Continue to record agreed actions from meetings where patients are discussed and reviewed, to evidence working in partnership with other relevant agencies and ensure patients' records reflected information shared to keep patients safe.
- Continue to embed the newly formed system of governance and ensure it is effective.

Hawthorn Drive Surgery had complied with the warning notice, however further improvements are required. These will be reviewed at the comprehensive inspection which is due when the special measures period ends.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Ensure that Medicines & Healthcare Regulatory Agency (MHRA) alerts identified as needing to be actioned are completed and the changes affected to ensure patients are safe and an effective process for checking that National Institute for Health and Care Excellence (NICE) guidance has been implemented appropriately.
- Continue to maximise the functionality of the computer system in order that the practice can run clinical searches, provide assurance around patient recall systems, consistently code patient groups and produce accurate performance data.
- Ensure that annual health reviews are offered for those patients with a learning disability who have not yet received one and that coding for patients with a learning disability is accurate.

Action the service SHOULD take to improve

- Continue to record agreed actions from meetings where patients are discussed and reviewed, to evidence working in partnership with other relevant agencies and ensure patients' records reflected information shared to keep patients safe.
- Continue to embed the newly formed system of governance and ensure it is effective.

Hawthorn Drive Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP Specialist Adviser.

Background to Hawthorn Drive Surgery

The practice area covers the Chantry Estate, in Ipswich, with a few patients from the nearby villages of Copdock, Washbrook, Sproughton and Burstall. The practice offers health care services to around 8250 patients. It is located in a building which was purpose built in 1984 and has consultation space for GPs and nurses.

The practice holds a Personal Medical Service (PMS) contract with the local CCG.

There are three GP Partners at the practice (two male and one female). There are two advanced nurse practitioners, two nurses and three healthcare assistants. A team of ten administration and reception staff support the practice manager.

The practice is open between 8am and 6.30pm Monday to Friday. Appointments are usually from 8.30am to 11.20am and from 3pm to 5.20pm for GPs and from 8am to 12.40pm and 2pm to 5.40pm for nurses. Extended hours appointments are offered between 8.40am and 12noon every Saturday. Patients are able to book evening and weekend appointments with a GP through Suffolk GP+. During out-of-hours GP services are provided by Care UK via the 111 service.

The practice has a larger number of patients between the ages of 0 to 34 and those over 85 than the national average. There are fewer patients between the ages of 35 to 84 than the national average. Income deprivation affecting children is 28%, which is higher than the CCG average of 14% and national average of 20%. The practice has a higher percentage of patients who are unemployed (9%) compared to the CCG average of 4% and the national average of 5%. Male and female life expectancy in this area is in line with the England average at 78 years for men and 83 years for women.

The CQC registration of the Partnership members and the Registered Manager was not up to date. The practice had been informed of this and need to ensure the relevant statutory notifications and applications are submitted.

Why we carried out this inspection

This inspection was carried out under Section 60 of the Health and Social Care Act 2008 to follow up from our previous comprehensive inspection of Hawthorn Drive Surgery on 14 November 2016. At our previous inspection we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014: Good Governance. We took action against Hawthorn Drive Surgery by issuing a warning notice.

How we carried out this inspection

We carried out a focused follow up inspection of Hawthorn Drive Surgery on 16 February 2017. During our visit we:

- Spoke with a range of staff including a GP, nurses, the practice manager and administration and reception staff.

Detailed findings

- Reviewed a sample of the personal care or treatment records of patients.
- Looked at information the practice used to deliver care and treatment plans.
- Reviewed documentation in relation to significant events, complaints, Medicines & Healthcare products Regulatory Agency (MHRA) alerts and NICE guidance.
- We reviewed meeting minutes, policies and procedures and details of governance structures within the practice.

Are services safe?

Our findings

At our previous inspection on 14 November 2016, we found that care and treatment was not being provided in a safe way for patients.

- The arrangements to ensure that patient safety alerts and agreed actions from significant events and complaints were actioned, were not adequate.

Safe track record and learning

All clinicians at the practice had registered to receive MHRA alerts and the clinicians we spoke to confirmed this. These were discussed at a number of practice meetings and we saw documented evidence of this. The practice manager collated all the MHRA alerts and these were reviewed by an identified GP lead. We saw that MHRA alerts received from January 2017 had been reviewed, appropriate action taken and a record kept of this. The practice had decided to review all the MHRA alerts from 2016. Some of these had been completed with changes affected, however two alerts had been identified as needing to be completed but had not yet been undertaken.

There was an effective system for recording and reporting of significant events. The practice had agreed and implemented a process for the sharing of learning and had a process for ensuring that actions had been completed. This was the same for complaints. The practice had four significant events since January 2017. We reviewed one of these and found that it had been discussed within the practice and shared with appropriate staff at relevant meetings. There was documented evidence of this in the meeting minutes that we reviewed.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 14 November 2016, we found that care and treatment was not being provided in an effective way for patients.

- The practice did not evidence that there was clinical joint working with other professionals to ensure shared information and management of risk.
- An accurate, complete and contemporaneous record was not maintained for every patient.
- The practice did not have effective and systematic systems to recall patients that required regular monitoring.

Effective needs assessment

All clinicians at the practice had registered to receive National Institute for Health and Care Excellence (NICE) guidance and the clinicians we spoke to confirmed this. These were discussed at a number of practice meetings and we saw documented evidence of this. The practice needed to ensure that these guidelines are implemented by undertaking audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

A data management team had been established to support the necessary improvements in relation to patient coding. Staff in this team had received training in this area. Protocols were in place to provide guidance to staff in relation to the management of paper, electronic and faxed information. These were in the form of a number of flowcharts. The practice had established a read code formulary, which detailed the agreed codes which would be used to code patients to ensure consistency of approach and to enable effective recall of patients who needed monitoring. Staff reported that these were useful for consistency of approach.

We reviewed one audit completed by the practice on 13 February 2017 which identified patients who were on the diabetic register with an HbA1c of less than 6.5 %, to establish why they were on the register without a diagnosis of diabetes (HbA1c is a standard test for diagnosing diabetes). 24 patients were found to be on the diabetic register without an HbA1c greater than 6.5%. Seven patients were removed from the diabetes register as they had been entered incorrectly. However the practice had kept 17 patients on the diabetes register as they wanted to monitor them as they were felt to be at greater risk of developing diabetes. This was discussed with two of the clinicians at the practice who decided that a more appropriate code would be used to identify this group of patients, as they were not diagnosed with diabetes.

During the inspection we found;

- 448 patients on the diabetes register. We reviewed the records of 5 patients and found one who was not diabetic.
- 1127 patients on the hypertension register. We reviewed 5 records and found evidence for the diagnosis and the treatment was appropriate.
- 183 patients were on the chronic obstructive pulmonary disease (COPD) register. We reviewed 4 records and found evidence for the diagnosis and the treatment was appropriate.
- 57 children were coded as having involvement with safeguarding. We checked a sample of patient records and found that patients had been coded appropriately.
- 36 health reviews for patients with a learning disability had been completed out of 59 and six were due to be booked. 17 patients were recorded as declining (informed dissent) however for some of these patients, the practice had been unable to contact them. The practice had not followed their own exception reporting protocol. The practice advised that work in this area was ongoing and had not been fully completed.

The practice had undertaken an audit of patients prescribed an inhaler with no diagnosis of asthma. They had identified the need for discussion and shared learning for the appropriate use of inhalers, the need for referral for diagnosis and the need to establish best practice.

The practice had established a system for the recall of patients who required monitoring, according to the month of their birthday. The practice had identified a GP, nurse and administration lead for each area of the Quality and Outcomes framework (QOF is a system intended to improve the quality of general practice and reward good practice). It was the responsibility of the leads for each QOF area to ensure that patients were invited for their review. We spoke with a number of staff who advised that coding had been the main priority as this needed to be accurate before effective recall could be undertaken. Staff we spoke with felt that the system in place for recall would be effective and that this was due to commence imminently.

Are services effective?

(for example, treatment is effective)

Coordinating patient care and information sharing

Multidisciplinary meetings had been scheduled on a quarterly basis throughout the year. One meeting had taken place in January 2017 and was attended by professionals including social care, community professionals, an Age UK representative and clinicians from the practice. We reviewed the minutes of the multi-disciplinary meeting and reviewed patient records to confirm that discussion and actions agreed for the patients discussed had been entered onto their record. The practice had established a template to use for future multidisciplinary meetings so that they could record this on the patients record whilst the patient was being discussed.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

At our previous inspection on 14 November 2016 we found that the GPs did not demonstrate that they had sufficient clinical and management oversight of the practice.

- Governance arrangements were insufficient in relation to patient safety alerts, significant events and complaints, accurate coding and subsequent monitoring of patients.

Governance arrangements

A number of meetings had been put into place and scheduled for 2017. At least one of each of these meetings had occurred and we looked at the minutes of each of the meetings. Set agendas had been written for each meeting. We saw that safety alerts, information from audits and discussion and leaning from significant events and complaints was shared appropriately with staff. An overall action log was in place and monitored by the practice manager. This detailed the actions needed from alerts and meetings held by the practice, when the action was to be completed by, which meetings the information needed to be shared with and when it had been completed. A framework for effective governance had been established, which needed to be embedded to ensure its efficacy.

Leadership and culture

An organisational chart had been written and shared within the practice. GP leads had been identified for clinical and managerial leadership areas of the practice. This included for example, multi-disciplinary team working, clinical coding and data quality, safeguarding, significant events and complaints, and leads for teams within the practice (nursing, reception and administration staff). Staff we spoke with were either aware of who the leads were or knew where to look to find this information. The practice had also identified a GP, nurse and administration lead for each area of the Quality and Outcomes framework (QOF is a system intended to improve the quality of general practice and reward good practice).

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Ensure that MHRA alerts identified as needing to be actioned are completed and the changes affected to ensure patients are safe. Ensure there is an effective process for checking that National Institute for Health and Care Excellence (NICE) guidance has been implemented appropriately. • Continue to maximise the functionality of the computer system in order that the practice can run clinical searches, provide assurance around patient recall systems, consistently code patient groups and produce accurate performance data. • Ensure that annual health reviews are offered for those patients with a learning disability who have not yet received one and that coding for patients with a learning disability is accurate.