Colney Hatch Lane Surgery

Quality Report

192 Colney Hatch Lane
London
N10 1ET
Tel: 020 8883 5555
Website: www.colneyhatchsurgery.co.uk

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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.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services well-led?	Good

Key findings

Contents

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Colney Hatch Lane Surgery on 2 August 2017. The overall rating for the practice was requires improvement. The full comprehensive report on 2 August 2017 inspection can be found by selecting the 'all reports' link for Colney Hatch Lane Surgery on our website at www.cqc.org.uk.

This inspection was an announced focused follow up inspection carried out on 20 February 2018 to confirm that the practice had carried out their plan to correct the issues that we identified in relation to identifying, monitoring and mitigating risks, knowledge of national guidelines incident reporting, quality improvement, involvement in multidisciplinary meetings, inadequate cytology rates and governance structure in our previous inspection on 2 August 2017. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice is now rated as good.

Our key findings were as follows:

- Although the practice now documented internal clinical meetings, there was no participation in multidisciplinary meetings.
- The practice had a good system of dealing with complaints, but did not discuss the learning and outcomes of complaints at relevant practice meetings.
- There was no system to identify vulnerable patients and there was no child safeguarding register.
- The practice vision and strategy with associated business plans were not formally documented and discussed.
- There was an open and transparent approach to safety and effective systems in place for recording and reporting significant events.
- The practice carried out risk assessments, including health and safety and fire safety.
- There was a process to review Quality Outcomes Framework (QOF) exception reporting rates where the practice was now achieving below the CCG and national averages.
- The practice had a system in place to monitor, review and improve inadequate cytology rates.
- There was evidence of quality improvement and the practice made good use of clinical audits.
- Clinical guidelines and patient safety alerts were discussed in clinical meetings where learning was shared.
- Blank prescriptions were secured and there use was effectively monitored.

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Summary of findings

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider should:

- Continue to work to improve inadequate cytology rates.
- Consider a system for multidisciplinary meeting involvement.
- Continue to monitor and review the child protection register.
- Review how vulnerable patients are highlighted on the clinical system.
- Ensure the system to discuss learning from complaints is implemented.
- Formalise the practice vision and strategy.

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

Key findings

Areas for improvement

Action the service SHOULD take to improve
Importantly, the provider should:

- Continue to work to improve inadequate cytology rates.
- Consider a system for multidisciplinary meeting involvement.
- Continue to monitor and review the child protection register.
- Review how vulnerable patients are highlighted on the clinical system.
- Ensure the system to discuss learning from complaints is implemented.
- Formalise the practice vision and strategy.

Colney Hatch Lane Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector, who was supported by a GP specialist advisor.

Background to Colney Hatch Lane Surgery

Colney Hatch Lane Surgery is located in Muswell Hill, North London. It is one of the member GP practices in Barnet Clinical Commissioning Group (CCG). The practice is located in the fifth less deprived decile areas in England. Census data shows 10% to 20% of the local population does not speak English as their main language. At 81 years, male life expectancy is higher than the England average of 79 years; and at 86 years, female life expectancy is higher than the England average of 83 years.

The practice has approximately 5,500 registered patients.

The practice population distribution is mostly similar to the England average although there is a greater proportion of patients in the 25 to 44 years age group and fewer patients in the 60 to 85 plus age groups. Services are provided under a General Medical Services (GMS) contract (a contract providing general primary medical services) with NHS England.

There are three GP consulting rooms and one treatment room. The GP principal and the salaried GP together provide the equivalent cover of two whole time GPs (both male). There is a regular locum GP who provides cover when needed and additional capacity in winter months when demand on the service is higher. There are two part time female practice nurses and a health care assistant. The practice also has a practice manager and a number of reception and administration staff members.

The practice's opening times are Monday to Friday 8am to 1pm and 2pm to 6:30pm and appointment times are as follows:

- Monday: 9am to 11:30am and 4pm to 8pm
- Tuesday: 9am to 11:30am and 4pm to 8pm
- Wednesday: 9am to 11:30am and 4pm to 6:30pm
- Thursday: 9am to 11:30am and 4pm to 6:30pm
- Friday: 9am to 11:30am and 4pm to 6:30pm

Urgent appointments are available each day and GPs also complete telephone consultations for patients. In addition, the practice is a member of the Pan Barnet federated GP's network; a federation of local Barnet GP practices which was set up locally to provide appointments for patients at local hub practices on weekday evenings and weekends when the practice is closed. There is also an out of hour's service that provides cover for the practice including telephone calls when the practice is closed.

Colney Hatch Lane Surgery is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, maternity and midwifery services and treatment of disease, disorder or injury from one location.

Why we carried out this inspection

We undertook a comprehensive inspection of Colney Hatch Lane Surgery on 2 August 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory

Detailed findings

functions. The practice was rated as requires improvement. The full comprehensive report following the inspection on 2 August 2017 can be found by selecting the 'all reports' link for Colney Hatch Lane Surgery on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of Colney Hatch Lane Surgery on 20 February 2018. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

Good

Are services safe?

Our findings

At our previous inspection on 2 August 2017 we rated the practice as requires improvement for providing safe services as the arrangements in respect of incident reporting and assessing and monitoring risks were not adequate.

These arrangements had significantly improved when we undertook a follow up inspection on 20 February 2018. However new issues in relation to safeguarding processes were identified. The practice is now rated as good for providing safe services.

Safety systems and processes

The practice had some systems to keep patients safe and safeguarded from abuse.

- The practice had vulnerable adults and safeguarding children policies which were regularly reviewed and outlined clearly who to go to for further guidance.
- There was no child protection register and the GP was not aware of whether there should be any children on this list. The practice did not have any multidisciplinary meetings where these children would be discussed. Following the inspection we were provided with a list of 25 children that were put on this register with the practice's ongoing plans and actions to monitor them.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.
- The practice had conducted safety risk assessments including fire risk and health and safety. It had a suite of safety policies which was communicated to staff. Staff received safety information for the practice as part of their induction and refresher training.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff, this was discussed at a practice meeting and the practice monitored the impact on safety.

Information to deliver safe care and treatment

Staff did not always have the information to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment, but there was no participation in multidisciplinary meetings to update and share information about vulnerable patients and patients with complex needs.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

Good

Are services safe?

- The systems for managing medicines, including vaccines and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation. PGD's are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. The health care assistant was trained to administer vaccines and medicines and patient specific prescriptions or directions (PSD) from a prescriber were produced appropriately. PSD's are written instruction, from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

Track record on safety

The practice had an effective safety record.

- There were risk assessments in relation to safety issues.
- The practice had begun to monitor and review activity to help it to understand risks and improve safety. For example as a result of a risk assessment, the practice was having fire doors installed.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. The GP and practice manager supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons and took action to improve safety in the practice. For example we viewed a significant event about the wrong patient details being entered onto the clinical system for a telephone consultation. This was discussed at a practice meeting where staff members were reminded to double check the details entered into the appointment slot to ensure it matches the right patient.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Good

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 2 August 2017, we rated the practice as requires improvement for providing effective services as the arrangements in respect of knowledge of national guidelines, inadequate cytology rates, quality improvement and multidisciplinary working needed improving.

These arrangements had improved when we undertook a follow up inspection on 20 February but further improvements in relation to multidisciplinary working was required. The practice is now rated as good for providing effective services.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older People

- Older patients who were frail or may be vulnerable received a full assessment of their physical and mental health and reviews of their medicines were carried out as appropriate.
- Health checks were available for patients aged over 75. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured their prescriptions and care plans were updated and reflected any changes.
- There were no multidisciplinary meetings where these patients were discussed.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- 69% of patients on the diabetes register had an IFCC HbA1c of 64mmol/mol or less in the preceding 12 months compared to the CCG average of 77% and the national average of 79%. There was an exception reporting rate of 8% which was the same as the CCG average and below the national average of 13%.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were between 87% and 94% for children aged under two years and 87% to 90% for five year olds, which was in line with the target percentage of 90%.
- The practice gave pre-conception and antenatal advice.
- The practice identified and reviewed the treatment of newly pregnant women on long-term medicines.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 69% compared to the CCG average of 64% and the 72% national coverage.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

Good

Are services effective?

(for example, treatment is effective)

- 75% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months, compared to the CCG and national average of 84%. There was an exception reporting rate of 0% compared to the national average of 7%.
- 84% of patients with schizophrenia, bipolar affective disorder and other psychoses had an agreed care plan documented in the record in the preceding 12 months compared to the CCG average of 91% and the national average of 90%. There was an exception reporting rate of 3% compared to the CCG average of 7% and the national average of 13%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 97%; CCG 92%; national 91%); and the percentage of patients experiencing poor mental health who had received discussion and advice about smoking cessation (practice 97%; CCG 96%; national 95%).

Monitoring care and treatment

The practice had a programme of quality improvement activity and reviewed the effectiveness and appropriateness of the care provided. For example the practice carried out an audit of foot checks for patients with diabetes with the aim to improve diabetic foot care. The audit involved reviewing all diabetic patients on the diabetic register. There were 278 patients on the register and as a result of reviewing and contacting these patients the practice increased its diabetic foot assessments from 58% to 91% on the previous 12 months.

The practice was aware that it had a high inadequate cytology rate at 8% and carried out quarterly audits to monitor this. This was regularly discussed at clinical and practice meetings and one to one sessions with the nurses where it was agreed that the nurses would undertake further training. The appointment booking process was changed to ensure that appointments would be booked mid cycle and cytology pots were now stored in a cool place. Upon further audit the practice found that out of two labs that samples were sent to all inadequate results were isolated to one lab; the nurses also worked at another practice which did not use that lab and had a 0% inadequate rate. The practice had brought this to the attention of the CCG and the laboratory where this was being discussed and investigated. The practice was also in the process of identifying a nurse who worked locally with a low inadequate cytology rate for the nurses to shadow.

The most recent published Quality Outcome Framework (QOF) results were 92% of the total number of points available compared with the national average of 97%. The overall exception reporting rate was 9% compared with a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate). The practice was not an outlier for any of the clinical domains measured.

The practice used information about care and treatment to make improvements. The practice decreased its exception reporting rates form 13% to 9% by carrying out a QOF audit where the GPs and nurses were given different long-term conditions to lead on with administrative support. All patients who previously had an exception reporting code entered into their record had their notes reviewed and where appropriate were called and appointment was made over the phone for a review of their condition. If the patient did not attend their appointment they received a telephone call from the nurse where another appointment would be booked.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisations and had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care

Good

Are services effective?

(for example, treatment is effective)

Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.

- There was a clear approach for supporting and managing staff when their performance was poor.

Coordinating care and treatment

Staff did not always work together effectively with other health and social care professionals to deliver effective care and treatment.

- The practice now had documented internal clinical meetings that involved the GPs and nurses, but the practice was not a part of multidisciplinary meetings where vulnerable patients and patients with complex needs could be routinely discussed with other external health care professionals.
- We saw records that showed all appropriate staff in the practice were involved in delivering care and treatment when this was required.
- Patients received person-centred care, which included when they moved between services, when they were referred or when they were discharged from hospital. The practice worked with patients to develop personal care plans.
- End of life care took into account the needs of patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- The practice carried out NHS health checks.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision and recorded the outcome in the patient record.
- The practice discussed the process for seeking consent appropriately in clinical meetings.

Are services well-led?

Good

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

Our findings

At our previous inspection on 2 August 2017, we rated the practice as requires improvement for providing well-led services as there was no overarching governance structure and systems to identify risks.

These arrangements had improved when we undertook a follow up inspection on 20 February 2018, however new issues in relation to the vision and strategy and sharing learning from complaints were found. The practice is now rated as good for being well-led.

Leadership capacity and capability

Leaders had the capacity and skills to deliver quality, sustainable care.

- Leaders had the experience, capability and integrity to deliver the practice strategy and risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood challenges including challenges with the premises and were addressing them.
- Leaders at all levels were visible and approachable. They worked with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

The practice did not have a formalised strategy to deliver high quality sustainable care.

- There was no documented vision, set of values, strategy or business plans. We were told that these were discussed informally. However staff we spoke with were able to describe the practice values and their role in achieving them.

Culture

The practice had a culture of quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- Clinical staff told us they focused on the needs of patients.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. For example, we saw that as a result of a complaint from a patient who was concerned about the appointment system as they were unable to get an emergency appointment, the patient was contacted an apology was given and an appointment was booked. However we saw that complaints were not routinely discussed at practice meetings where learning and outcomes could be shared. We were shown a new standing agenda for practice meetings which included complaints which would be used from March 2018.
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management; however these were not always adhered to.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of clinical relationships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.

Are services well-led?

Good

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

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control but systems to identify vulnerable patients and safeguarding children were not effective.
- Practice leaders had established proper policies and procedures, however these were not always fully implemented for example learning from complaints was not always shared with relevant staff members and the system for recording children at risk of abuse was not effective.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. For example, the practice carried out a health and safety risk assessment of the premises and a fire risk assessment.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of low performing areas such as inadequate cytology, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints which were all on spreadsheets that were updated and reviewed.
- Clinical audit had a positive impact on quality of care and outcomes for patient. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information, including information obtained from the CCG was used to improve performance. Performance information was combined with the views of patients.
- Quality and sustainability was not formally discussed in relevant meetings.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, staff and external partners to support quality sustainable services.

- Patients, staff and external partners were encouraged to voice their views and concerns.
- There was an active patient participation group.
- The service was transparent, collaborative and open with stakeholders about performance.