Hendon Way 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.

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Letter from the Chief Inspector of General Practice

We had previously carried out an announced comprehensive inspection at Hendon Way Surgery on 11 October 2017. Overall the practice was rated as inadequate and placed in special measures. We identified concerns with regards to safe, effective, responsive and well-led care provided by the practice.

We served warning notices under regulations 17 (good governance) and 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The report for the comprehensive inspection can be found by selecting the 'reports' link for Hendon Way Surgery on our website at: http://www.cqc.org.uk/location/1-1593169343.

The practice sent us a plan of action to ensure the service was compliant with the requirements of the regulations. We undertook a focussed inspection on 19 March 2018 to review the breaches of regulation identified at the inspection in October 2017 and to ensure the service had made improvements. At this inspection we did not review the ratings for the key questions; we will consider the practice's ratings when we carry out a comprehensive inspection at the end of the period of special measures.

At the inspection on 19 March 2018 we found that the practice had made significant improvements and were no longer in breach of regulations 17 and 18.

Key findings

Our key findings across all the areas we inspected were as follows:

- There was evidence of completed two cycle clinical audits identifying quality improvement to patient care.
- There was a comprehensive system in place to ensure the safe management of high risk medicines.
- Improvements to governance systems had been made. For example, the practice was able to provide evidence that processes for managing uncollected prescriptions and patient safety alerts were improved and staff were adhering to the improved protocols.
- Systems for managing staff training and induction were significantly improved.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services effective?
We have not reviewed the rating for this key question.

Are services well-led?
We have not reviewed the rating for this key question.

Hendon Way Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Led by a CQC Lead Inspector**.** The team included a GP specialist adviser, a practice nurse specialist adviser and a second CQC inspector.

Background to Hendon Way Surgery

Hendon Way Surgery is located in the London Borough of Barnet within the NHS Barnet Clinical Commissioning Group. The practice holds a General Medical Services contract (an agreement between NHS England and general practices for delivering primary care services to local communities). The practice provides a full range of enhanced services including childhood immunisation and vaccination, meningitis immunisation, extended hours access, dementia support, influenza and pneumococcal immunisations, learning disabilities support, rotavirus and shingles immunisation and unplanned admissions avoidance.

The practice is registered with the Care Quality Commission to carry on the regulated activities of family planning, maternity and midwifery services, treatment of disease, disorder or injury and diagnostic and screening procedures.

The practice address is 67 Elliot Road, Barnet, London, NW4 3EB. The practice had a patient list size of 8,773 at the time of our inspection. The practice are relocating to new premises on 1 April 2018; the new address is 215 West Hendon Broadway, Barnet, NW9 7DG. The practice told us they are expecting a decrease in the number of registered patients as a result of the relocation; the list size is predicted to reduce to approximately 6,000 patients.

At the inspection on 11 October 2017, the clinical team at the practice included four GP Partners (two females, two males), one locum practice nurse (female) and one full-time midwife (female). As part of the practice's plan to improve services the leadership team began recruitment to expand the clinical team. A full time practice nurse was hired and would begin working for the service on 1 April 2018. An advanced nurse practitioner was recently offered a part-time position at the practice; the start date was not confirmed at the time of our inspection. In addition, the practice was in the process of recruiting a full-time healthcare assistant to join the clinical team and there was a locum phlebotomist (male) in post.

At the inspection on 11 October 2017, the non-clinical team at the practice included one practice manager, an interim practice manager covering maternity leave, which was due to finish on 1 April 2018, and seven administrative staff. As part of the practice's plan to improve services the leadership team recruited two additional members of non-clinical staff.

The practice is open Monday to Friday from 8am to 6.30pm. Phones lines are closed daily between 1pm and 2pm and covered by the practices out of hours provider during this time. The surgery closes every Wednesday between 12.30pm and 2pm for training purposes.

Extended hours access is available Monday to Friday from 6.30pm to 7.10pm for pre-booked appointments.

Urgent appointments are available each day and GPs also provide telephone consultations for patients. An out of

hour's service is provided for patients when the practice is closed. Information about the out of hour's service is provided to patients on the practice website and the practice phone system.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 on 11 October 2017 as part of our regulatory functions. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Breaches of legal requirements were found and warning notices were issued in relation to the practice providing effective and well-led services at our previous inspection in October 2017. As a result, we undertook a focused inspection on 19 March 2018 to follow up on whether action had been taken to address the breaches outlined in the notices.

Are services effective?

(for example, treatment is effective)

Our findings

Management, monitoring and improving outcomes for people

At our comprehensive inspection in October 2017, we found that the practice had limited evidence of quality improvement. The practice provided us with evidence of first cycle clinical audits however; there was no evidence of completed two cycle clinical audits which resulted in quality improvement. For example:

- There had been seven clinical audits commenced in the last two years, however none of these were completed audits where the improvements made were implemented and monitored.
- Following the inspection the practice submitted a second cycle for the audit of inadequate smears completed on 3 October 2016. The audit from October 2016 showed an inadequate smear rate of 5% for the period 1 September 2015 to 31 September 2016; the frequency of the audit was listed as 'at least every two years'. The first audit cycle identified a total of 395 smears were performed during this period between three sample takers at the practice with an adequate rate of 5% overall. The audit did not include the number of smears performed per sample taker and therefore did not effectively measure whether additional training was required to improve the service.

At our focussed inspection in March 2018, we saw that the practice had four completed two-cycle clinical audits. All four of these audits identified quality improvements in patient care. For example, a first cycle audit was conducted in August 2016 to identify if patients who were prescribed carbimazole had had blood tests within the last 12 months in line with NICE guidance. Carbimazole is a medication used in the treatment of hyperthyroidism (hyperthyroidism is a condition where the thyroid gland produces too much thyroid hormone for the body's needs). The identified that a total of 12 patients were being treated with carbimazole, six of the patients had not had blood tests carried out within the previous 12 months. The second cycle audit was conducted on 30 October 2017 and confirmed improvement in the care of patients prescribed carbimazole as all 12 patients had completed blood tests within the previous 12 months.

Effective staffing

At our inspection on 11 October 2017 we had concerns regarding the ineffective systems for managing staff training and induction. At the focussed inspection in March 2018 we found that the practice had made significant improvements to both the training and induction systems. The practice were able to provide evidence that new and long term members of staff were given the support and training required to fulfil their roles. For example:

Induction programme

At the comprehensive inspection in October 2017 the practice were unable to provide evidence of a formal induction programme. The practice provided a new recruit welcome/induction checklist as evidence of the induction programme. However, the checklist did not include competencies required by new members of staff in order to fulfil their role.

We reviewed staff files for two members of staff that were employed within the last 12 months. There was no formal induction information in either file to show that these new members of staff had been assessed as competent in their new roles or to indicate what competencies were relevant to their roles. We spoke to both of these members of staff on the day of inspection and we were told that they were given on the job supervised training; however they had not had any formal reviews to assess the competencies required for their roles. They also told us that they did not have one to one meetings with their line manager during their probationary periods to review their progress against the supervised training for their roles.

At the focussed inspection in March 2018 the practice were able to provide evidence that significant improvements had been made to the induction programme. The new programme included a comprehensive staff induction policy. The policy stated that all new members of staff would begin the induction programme on their first day of employment; newly appointed staff were not permitted to work unsupervised until they had successfully completed the induction programme.

The induction programme had a structured recruitment induction checklist which ensured all required recruitment checks were completed prior to employment commencing. The programme documented all information given to the new member of staff, including an introduction to the practice, terms and conditions of employment, practice specific policies, mandatory training requirements and

expected performance standards. The programme also included role specific competency requirements. During the induction programme new members of staff met with their line manager every two weeks to review progress against the programme and to allow staff the opportunity to provide feedback on the programme, ask questions or request additional support.

We asked to see evidence of induction for the two newest members of staff. The practice provided us with documentation signed by the new member of staff and their line manager which evidenced that they had completed the recruitment induction checklist, documentation checklist and the role specific competency requirements. The practice also provided evidence of fortnightly reviews during the induction process.

In addition to the evidence provided around the new induction programme, the practice provided evidence that they had acted on staff feedback about the process. For example, as a result of staff feedback, the role specific competency requirements were expanded to include details of each task related to areas of work. This allowed staff to easily recall detail and discuss progress during their fortnightly induction review meeting.

Staff Training

At our inspection on 11 October 2017 we had concerns regarding the systems for managing staff training which proved to be ineffective. Specifically, the practice had difficulty providing evidence to show that staff had the skills and knowledge to deliver effective care and treatment. We asked for additional evidence of training following the inspection, and most of the evidence we asked for was received. However, the additional evidence provided highlighted that the system for managing the training needs for staff was ineffective. The practice was unable to demonstrate how they ensured role-specific training and updating for relevant staff. We were told that training was monitored by reviewing individual staff files to identify which training had not been completed. However, we found inconsistencies in training completed by staff when we reviewed four staff files. For example, of the four files we reviewed, two members of clinical staff did not have evidence of completed infection and prevention control training (IPC) where as two members of non-clinical staff did have evidence of completed IPC training. Following the inspection the practice submitted evidence of completed IPC training for one of the clinical members of staff whose file we reviewed at the inspection. However, the practice was unable to provide us with assurance that there was an effective system in place for ensuring staff were appropriately trained to perform their roles.

The practice told us that all staff completed training for safeguarding, fire safety awareness, basic life support, infection and prevention control and information governance. Staff files we reviewed on the day of inspection did not have evidence of training certificates for training indicated as mandatory by the practice. We found that the log of staff training was inaccuracte. In some instances it did not capture training that staff had completed and there were areas marked as completed with no evidence of certification. We were not provided with assurance that the practice had an adequate system in place to accurately record and monitor staff training.

At the focussed inspection in March 2018 the practice told us that they had introduced a training matrix along with a list of required mandatory training for the management of staff training. We reviewed training for a random sample of three clinical and four non-clinical members of staff. All staff we reviewed had completed the required mandatory training; this was evidence by training certificates of completion on file for each member of staff. These findings aligned with the information recorded on the staff training matrix and the required mandatory training. For example, we saw evidence that all staff were up to date with training for basic life support, fire safety, infection and prevention control, mental capacity act and safeguarding.

Are services well-led?

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

Our findings

Governance arrangements

At our comprehensive inspection in October 2017 we found that there were systemic weaknesses in governance systems. We had concerns around the in effective processes for quality improvement, uncollected prescriptions, high risk medicines and patient safety alerts. At the focussed inspection on 19 March 2018 we found the practice had made improvements to the governance systems for all of these areas. For example:

Quality Improvement

At the comprehensive inspection in October 2017 we were told there was a programme of continuous clinical and internal audit used to monitor quality and to make improvements. We were provided with seven clinical audits; however none of these were completed two cycle audits. Following the inspection a second cycle was completed and submitted in relation to cervical screening, the findings of this audit are detailed under the 'effective' domain in this report. However, the audit did not demonstrate quality improvement as a result of lessons learned from the first cycle audit.

At the focussed inspection in March 2018 the practice told us that they had improved the governance process for quality improvement and provided us with a programme of clinical audits. The programme identified seven clinical audits to be undertaken, the rationale for selecting the audit subject, the clinical lead for each audit, dates of the audit cycle including dates for re-audits. In addition, the practice was able to provide evidence of four completed two-cycle clinical audits all of which showed quality improvement to patient care. The programme of clinical audits was scheduled up to March 2019. This provided us with assurance that leadership had oversight of the new governance process and had identified quality improvement as a priority.

Uncollected Prescriptions

At the comprehensive inspection in October 2017 we were not provided with evidence of effective arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. We found that there was no clinical oversight for uncollected prescriptions. We reviewed the practice policy for uncollected prescriptions; the policy stated uncollected prescriptions would be checked every three months by a receptionist. The policy did not state that a clinician must review the uncollected prescriptions and did not indicate what the process was for dealing with uncollected prescriptions. We spoke to three members of staff on the day of inspection. We were told by one member of staff that uncollected prescriptions were checked once a month and a note was made on the patient record to state that the prescription had not been collected, the prescription would then be disposed of in confidential waste. The other two members of staff told us that uncollected prescriptions were checked every month by reception staff and shredded or disposed of in confidential waste. We looked at the uncollected prescriptions on the day of inspection and found that one was six weeks old and one was eight weeks old.

At the focussed inspection in March 2018 we reviewed the updated protocols for uncollected prescriptions. The practice had appointed a clinical lead for uncollected prescriptions and non-clinical members of staff that we spoke with were able to name the clinical lead. The new protocols stated that reception staff should check the uncollected prescriptions weekly, any prescriptions over four weeks old were to be passed to the clinical lead or the duty doctor for review. If instructed to destroy the prescription by the clinician, reception staff were given a specific code on the patient's record indicating that the prescription had not been collected. We reviewed the uncollected prescriptions on the day of inspection and found that there were no prescriptions over three weeks old.

High Risk Medicines

At the comprehensive inspection in October 2017 we asked for the practice protocol for the management of high risk medicines. The protocol shared with us did not identify what a high risk medicine was, did not include NICE guidance or any other nationally recognised clinical guidance or describe the frequency and type of monitoring required in order to ensure safe management of high risk medicines. We reviewed records for patients on warfarin, methotrexate, azathioprine and lithium. We found that the process for managing these high risk medicines was not consistent across the practice. We found examples for each of these high risk medicines where patients had been issued with prescriptions without the appropriate monitoring information being available to the prescriber.

Are services well-led?

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

Following the inspection we wrote to the practice in relation to our concerns about the safety of patients being issued high risk medicines. The practice responded and provided us evidence that a clinical review of all patients on high risk medicines had been conducted. The practice produced a policy for the management of high risk medicines which contained national clinical guidance. A GP partner was nominated as the lead for the management of high risk medicines and would be responsible for overseeing monthly reviews to ensure protocols for the safe management of high risk medicines were being followed.

At the focussed inspection on 19 March 2018 the leadership team demonstrated there was a strong focus on the safe prescribing of high risk medicines. We reviewed the new policy for high risk medicines; there was a named clinical lead for each type of high risk medicine. Clinical leads proactively reviewed prescribing practice on a monthly basis. In addition to monthly checks, the practice provided three completed two-cycle audits undertaken to ensure safe prescribing for high risk medicines was being followed by all prescribers. We reviewed prescribing for warfarin, lithium, methotrexate and azathioprine. We looked at the records for all of the patients on lithium and azathioprine and 60% of patients on methotrexate and warfarin. We found that there was clear clinical evidence of blood test monitoring within three months of prescriptions being issued for every record we reviewed.

Patient Safety Alerts

At the comprehensive inspection in October 2017 we found there was an inconsistent process for recording and reviewing patient safety alerts. The practice submitted an audit which outlined the action taken for four patient safety alerts. The audit clearly identified action taken by the practice in relation to the safety alerts. We asked the practice to provide evidence of how they monitored safety alerts and decide which alerts required action to be taken. Apart from the audit, the practice were unable to evidence the process by which alerts were received, recorded and discussed to decide whether they were relevant to the practice and what action should be taken.

At the focussed inspection in March 2018 we found that the practice had introduced a formal system for recording all patient safety alerts; this included alerts received that were not relevant to general practice. All GPs were signed up to receive patient safety alerts directly, in addition the practice manager received all alerts and was responsible for recording these alerts and ensuring all clinicians at the practice were of new alerts. We saw evidence that alerts were discussed at clinical meetings and all clinical staff we spoke to on the day of inspection were able to provide examples of recent alerts. We reviewed the log where alerts were recorded and we saw that where alerts were relevant to the practice there was a clear audit trail indicating the clinical lead, required action and date action was completed. For example, we reviewed a local alert relating to a faulty laboratory kit and saw evidence that the practice had taken appropriate action and recorded the process in the patient safety alert log.