Heathway Medical Centre

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 Heathway Medical Centre on 26 May 2016. Breaches of legal requirements were found in relation the governance arrangements in the practice. We issued the practice with a warning notice for regulation 17, Good governance, requiring them to achieve compliance with the regulation by 9 September 2016. We found that the provider did not have effective governance processes and systems in place to keep people safe.

We undertook a focused inspection on 7 November 2016 to check that the practice had addressed the issues in the warning notice and now met the legal requirements. This report only covers our findings in relation to those requirements.

At the inspection, we found that the requirements of the warning notice had been met.

Our key findings across the areas we inspected for this focused inspection were as follows:

Summary of findings

- The practice had made improvements since our last inspection. We found patient records were now stored in secure and lockable cupboards.
- We saw there was now a system in place for reporting and recording significant events.
- We saw clinical audits had been carried out to show patient improvements.
- We found that healthcare assistants had adopted patient specific directions (PSDs) to ensure vaccines and medicines administered by them were in line with legal guidance.
- We found that an infection control lead had been appointed and an audit had been carried out and action had been identified.
- The practice had updated several policies, including safeguarding adults and children, health and safety, mental capacity act policy, clinical governance, information governance, confidentiality and whistle blowing policy. These were now practice specific and all staff had access to them on the practice computer system.
- We found that all staff had records of Disclosure and Barring Service (DBS) checks in their personnel files as outlined in the practice recruitment policy and the practice manager was still in the process of collecting all other necessary documentation .
- The practice had initiated a patient participation group. The practice had systems in place to record and respond to complaints and we found the correspondence was documented and recorded.

The areas where the provider should make improvements are:

- Ensure systems for managing all significant events include records of details of actions taken, learning outcomes shared with staff and affected patients.
- Ensure staff files are kept up to date with recruitment checks completed, including checks with the relevant professional body.
- Ensure a formal induction programme is implemented when staff are newly appointed into the practice.
- Ensure all practice meetings are recorded and minutes are made available to all staff.

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?

In our report, published 1 September 2016 an error had been made on the reporting of the Quality and Outcomes Framework (QOF). This report contains an updated report of unverified data for the provider. This does not affect the rating of this domain or any others.

Are services well-led?

- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular team meetings.
- There was a governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- Ensure systems for managing all significant events include records of details of actions taken, learning outcomes shared with staff and affected patients.
- Ensure staff files are kept up to date with recruitment checks completed, including checks with the relevant professional body.
- Ensure a formal induction programme is implemented when staff are newly appointed into the practice.
- Ensure all practice meetings are recorded and minutes are made available to all staff.

Heathway Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a second CQC inspector.

Background to Heathway Medical Centre

Heathway Medical Centre is based in a purpose built building, shared with another GP practice, located in a residential area in Dagenham. The building is managed by NHS Properties. There is suitable patient access to the premises and patient parking, including disabled parking. At the time of our inspection there were approximately 4,000 patients registered with the practice. They also take care of 60 residents from a care home. These patients are elderly and require specialist care in dementia, Alzheimer's and Parkinson's disease.

Primary medical care is provided under a General Medical Services (GMS) contract within NHS Barking and Dagenham Clinical Commissioning Group (CCG). The practice is registered with the Care Quality Commission (CQC) to provide the regulated activities of: treatment of disease, disorder or injury; surgical procedures; diagnostic and screening procedures; family planning services; and maternity and midwifery services at one location.

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 26 May 2016 as part of our regulatory functions. The inspection was planned to check whether the provider is 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 a warning notice was issued in relation to good governance. As a result, we undertook a focused inspection on 7 November 2016 to follow up on whether action had been taken to address the breaches outlined in the notice.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. We carried out an announced visit on 7 November 2016. During our visit we:

- Spoke with a range of staff including, GPs, practice manager, healthcare assistant and four administrative staff.
- Reviewed documentation relating to the practice including policies and procedures.

Are services effective?

(for example, treatment is effective)

Our findings

Management, monitoring and improving outcomes for people

In our report, published 1 September 2016 an error had been made on the reporting of the Quality and Outcomes Framework (QOF). This report contains an updated report of unverified data for the provider. This does not affect the rating of this domain or any others.

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 97.1% of the total number of points available. The practice was not an outlier for exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. The practice did not submit data on time for 2014/15 QOF to be verified for the inspection as such the unverified data from this period showed:

- Performance for diabetes related indicators was above the national average. For example, For example, 100% of diabetic patients had had their last blood sugar reading of 64 mmol/mol or less in the last 12 months compared CCG average 72% and national average 78%. However, exception reporting was 20%, which was higher than CCG average of 15% and national average of 12%. However, the exception reporting for diabetes indicator overall was not an outlier.
- Performance for mental health related indicators was similar to the CCG and national average. For example, all 39 patients on the mental health register had had a comprehensive, agreed care plan documented in their records in the last 12 months, compared to the CCG average of 89% and national average of 88%.
- Performance for dementia related indicators was similar to CCG and national average. For example, 96% of people diagnosed with dementia had had a face-to-face care plan review in the last 12 months, compared to the CCG and national average of 84%.

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 inspection on 26 May 2016 the provider did not have an effective governance framework to deliver their vision of good quality care.

- We found that key policies were generic and did not have up to date or relevant information, including significant events, safeguarding, information governance, health and safety, recruitment, chaperone and Mental Capacity Act. Staff were not able to demonstrate how they would access practice policies. We were told by the provider that practice policies were not being used and needed to be reviewed.
- We found that the practice had a generic recruitment policy, which they were not following. We reviewed five staff files and found that these did not contain documents outlined in the recruitment policy, including no record of references and no records of DBS checks for relevant staff.
- We saw evidence of one set of data collection carried out; however, there was no programme in place to for continuous clinical and internal auditing to be used to monitor quality and to make improvements.
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not in place. The provider told us that infection control audits were not carried out. We found that the provider did not have safe systems to ensure vaccinations and medicines administered by the healthcare assistant were in line with guidance. We found the healthcare assistant was administering vaccines without the documented authorisation of the GP.
- We found that patient records were not kept in a secure location and were accessible by cleaning staff.

At our inspection on 7 November 2016, we found that the practice had a governance framework, which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- Practice specific policies were implemented and in line with published guidance. These were available to all staff. Staff could access these on the practice computer system and there was also a hard copy in the practice manager's room. We saw that the practice manager had reviewed and updated a number of key policies including: safeguarding adults and children, health and safety, mental capacity act policy, clinical governance, information governance, confidentiality and whistle blowing policy. We saw that each policy had attached a staff list and we saw signatures and dates of staff that had read the policy. We found that non-clinical staff had signed the policies to say they had read them.
- The practice had reviewed their recruitment policy and although they had not recruited new staff since updating their policy, they had reflected on their current staff files. We reviewed five staff files and found all had records of Disclosure and Barring Service (DBS) checks for relevant staff, proof of identification including photo and written references. We saw the practice manager was working to gather evidence of registration and qualifications for clinical staff. We also saw that the practice manager was working on creating an induction programme for newly appointed staff.
- A programme of continuous clinical and internal audit had been implemented to monitor quality and to make improvements. We saw that the practice had completed a two-cycle audit on drugs used in patients with heart failure. The practice used the NICE guidance to audit their practice and prescribing of ACE-I (ACE inhibitors are medicines that are used to treat high blood pressure). The practice showed that they had improved prescribing for ACE-I in patients with heart failure from 48% in December 2015 to 75% in April 2016. In April 2016 they found that 25% of patients with heart failure were not suitable for the drug. We saw that the practice had also planned to complete a second audit cycle on the flu vaccination uptake in children in January 2017 and we also saw a plan of four other audits that they were planning to carry out in 2017.
- The arrangements for identifying, recording and managing risks, issues and implementing mitigating actions had been improved. For example, the provider had carried out an infection control audit in November 2016. We saw that action points were discuss at practice meetings where all staff attended and all identified actions had been completed. We saw that the practice proposed to review the audit annually. We saw evidence of healthcare assistants using Patient Specific Directions (PSDs) to gain documented authorisation from a GP before administering any vaccines and medication to people.

Are services well-led?

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

- We saw that all patient records were kept in secure and lockable cabinets which could only be accessed by the practice staff.

Leadership and culture

At our inspection on 26 May 2016 the provider did not have effective systems in place for reporting, recording, acting on, learning from and monitoring significant events. There was a policy that outlined the process to follow but the provider was not following this. The provider had recorded one significant event in the last 12 months however when we spoke to staff they were able to give examples of at two others which had not been recorded. The provider told us that significant events were discussed informally with all staff, however when we spoke to staff they were not aware of the significant events.

At our inspection on 7 November 2016, we found that the provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. We saw all staff were now involved with recording and reporting incidences and recording forms were available in the receptionists desks. We saw that action points had been included, however learning outcomes were not always clear and dates of when actions were to be completed by were not always recorded or reviewed by management. We did see when more serious incidences were identified, these were dealt with immediately and discussed formally with all staff in practice meetings and outcomes were shared and implemented.

Seeking and acting on feedback from patients, the public and staff

At our inspection on 26 May 2016 the provider did not proactively encourage feedback from patients. They did not have a Patient Participation Group (PPG) to seek feedback from. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with management during staff meetings; however, they could not give examples of this. Staff meetings were not documented.

At our inspection on 7 November 2016 we found that the practice had encouraged feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service and taken action as a result.

- The practice had gathered feedback from patients through the patient participation group (PPG) and complaints received. The PPG had been newly set up since September 2016 and had met twice. We saw PPG meeting minutes where they had submitted proposals for improvements to the practice management team. For example, we saw that members had raised concerns about the difficulty in parking in the practice car park. In response, the practice manager discussed this with the building manager and is still working to come to a better arrangement for patients. We saw members had also identified that not all patients were aware or understood the out of hours service and as a result the practice manager observed how reception staff informed patients about this service. He then trained them to better promote and make patients more aware of what the out of hours service was.
- The practice had gathered feedback from staff through staff meetings and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they now felt involved and engaged to improve how the practice was run.

Listening and learning from concerns and complaints

At our inspection on 26 May 2016 the provider did not have systems for seeking feedback from patients for evaluating and improving the services. The provider did not keep records of complaints to identify themes and learning and we did not see evidence of correspondence with people who complained. However, on the day of inspection the practice manager found four written complaints, which had not been acknowledged by the provider as per their complaints policy.

At our inspection on 7 November 2016, we found that the practice had implemented a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

Are services well-led?

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

- There was a designated responsible person, who handled all complaints in the practice.
- We saw that information was available and leaflets in the waiting room to help patients understand the complaints system.
- We saw there had been four complaints received since September 2016. We saw evidence that they had been fully investigated, with transparency and openness. Lessons were learnt from individual concerns and complaints, where necessary these were also treated as a significant event. Action was taken as a result to improve the quality of care. We saw that the practice had identified a trend, in particular about the attitude of staff. The practice told us that the lead GP was working closely and with the staff and providing mentorship. As a result, we saw that in October 2016, the staff had received three positive comments on the NHS Friends and Family test.