

Care Quality Commission

Inspection Evidence Table

Rushey Mead Health Centre (1-2822986427)

Inspection date: 19th, 27th and 31st May 2021

Date of data download: 19 May 2021

Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe

Rating: Requires Improvement

At the inspection on 24th and 30th October 2019 we rated the practice as requires improvement for providing safe services because:

- Staff recruitment practices were not consistently followed and there were gaps in the staff recruitment documents available in staff files.
- There was a lack of records to demonstrate that the provider had ensured that all staff were up to date with immunisations relevant to their role.
- The chaperone procedure did not indicate that staff should position themselves where they could see the patient and what the nurse or doctor were doing.
- Equipment cleaning records were not fully completed to confirm that the cleaning process had been carried out correctly.

At this inspection we rated the practice as Requires Improvement for Safe services because:

- At this inspection we found that most of the concerns had been addressed but the provider needed to ensure that health and safety issues identified were followed up and acted on in a timely manner.
- A system was now in place for staff recruitment and retention
- Records were kept in regard to staff immunisations
- Chaperone policy was now in place which gave guidance to staff
- Equipment cleaning records and an ear syringing protocol was in place to provide guidance to staff.

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse.

| Recruitment systems | Y/N/Partial |
|---|-------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Yes |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>We saw records that demonstrated that since the last inspection the practice had improved their recruitment processes. Recruitment processes were centralised at Spirit Healthcare Head office. A recruitment guide had been put in place along with an employee documentation pack which gave guidance to managers on what documents were required.</p> <p>The practice ensured that their recruitment and selection procedures had the appropriate checks in place, along with current registration with a professional regulator where appropriate. Disclosure and Barring Service (DBS) checks were completed. (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 have contact with children or adults who may be vulnerable). Non-clinical staff who undertook chaperone roles had DBS checks completed and had received chaperone training. A chaperone policy was now in place</p> <p>We saw evidence in place which contained all staff information relevant to recruitment and staff immunisations relevant to their role. They had also carried out risk assessments where historic information was missing from staff files, for example, staff references, curriculum vitae, interview questions.</p> <p>As this was a desktop review, we were not able to check individual staff files.</p> | |

| Safety systems and records | Y/N/Partial |
|---|------------------|
| <p>There was a record of portable appliance testing or visual inspection by a competent person.</p> <p>Date of last inspection/test: 24 September 2019</p> | Yes ¹ |
| <p>There was a record of equipment calibration.</p> <p>Date of last calibration: 5 July 2019</p> | Yes ¹ |
| <p>Explanation of any answers and additional evidence:</p> <p>At the inspection in October 2019 we found that there were records of portable appliance testing and equipment calibration. The practice had maintained a log of the cleaning and sterilisation of the machine used for irrigating patients' ears. However, the information requested in the log did not allow for confirmation that the cleaning process had been carried out appropriately.</p> | |

At this inspection equipment cleaning records were in place along with an ear syringing protocol to provide guidance to staff. An equipment policy was in place, dated October 2016. We were told it had been reviewed in July 2020 and was due to be reviewed again in May 2021.

| Health and safety | Y/N/Partial |
|--|-------------|
| Premises/security risk assessment had been carried out. Date of last assessment: 3 rd March 2021 Health and Safety Inspection Report | Partial |
| Health and safety risk assessments had been carried out and appropriate actions taken. | Partial |

Explanation of any answers and additional evidence:

At this inspection the Care Quality Commission asked for an update on the Health and Safety Action Plan viewed in March 2019. We also reviewed the latest Health and Safety inspection report dated 3 March 2021

The building was shared with Leicestershire Partnership Trust (LPT) and managed by NHS Properties Services, relevant health and safety checks were initiated and carried out by them. In 2019 there were a number of outstanding actions required, for example an annual asbestos inspection.

It was annotated in the 2021 report that the provider had in place the required maintenance schedule for building and equipment and records were kept. However, the provider was asked to check and confirm a number of areas in regard to a fire alarm service, completion of remedial actions for emergency lighting, and date of last fire drill, They were also asked for a copy of last electrical installation condition report and confirm asbestos risk assessment dated 2017 had been re-inspected. In addition, they needed to confirm water hygiene legionella risk assessment had been completed since 2018 and water temperature monitoring was carried out and documented.

We asked to see evidence of the actions from the 2021 health and safety report. The water hygiene legionella risk assessment had not been re-inspected but remedial works had been carried out on 5 March 2019. At the time of this inspection no new date had been identified for a new risk assessment to be carried out. Water temperature monitoring took place monthly by an external contractor. Fire risk assessment was dated 3 February 2020, with no outstanding actions but had an advisory to install fire doors with combined seals and intumescent strips. Monthly fire alarm and emergency lighting testing took place. No updated information was available in regard to the fixed electrical wiring certificate, asbestos risk assessment, latest fire drill and fire alarm servicing.

Regular health and safety walk rounds were carried out by the practice to continue to ensure that the premises were safe. Although we were told they took place monthly we saw that there were gaps in January and February 2021.

Infection prevention and control
Responding to Covid 19 Pandemic

| | Y/N/Partial |
|---|-------------|
| There was an infection risk assessment and policy. | Yes |
| Risk assessments had been carried out in relation to Covid 19 | Yes |
| Explanation of any answers and additional evidence: From the information reviewed at this desk top inspection we saw that the practice had continued to maintain services during Covid 19 and had reviewed its ways of working to respond to the pandemic. Standard Infection Control measures were in place to reduce the risk of transmitting infectious agents from both recognised and unrecognised sources of infection. Covid 19 and infection prevention and control were regularly discussed at provider level to ensure that resources were in place to implement and measure adherence to good IPC practice. | |

Effective

Rating: Good

At this inspection the practice remained Good overall for providing Effective Services and we rated the population group of Families, Children and Young People as Good because:

- Improvements had been made to childhood immunisation uptake.

At this inspection the population group of Working Age People (including those recently retired and students) remained Requires Improvement because:

- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period was below 70% and below the national target of 80%.
- Improvements had been made so that people were able to access care and treatment in a timely way.

Families, children and young people

Population group rating: Good

| Findings | | | | |
|---|-----------|-------------|------------|---------------------------------|
| <ul style="list-style-type: none"> • The practice had improved the five childhood immunisation indicators since the last inspection. • The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary. • A protocol was in place for childhood immunisations, but we found it was not dated and did not have a version control. | | | | |
| Child Immunisation | Numerator | Denominator | Practice % | Comparison to WHO target of 95% |
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England) | 29 | 31 | 93.5% | Met 90% minimum |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England) | 38 | 40 | 95.0% | Met 95% WHO based target |
| The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England) | 37 | 40 | 92.5% | Met 90% minimum |

| | | | | |
|---|----|----|--------|--------------------------|
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England) | 38 | 40 | 95.0% | Met 95% WHO based target |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England) | 30 | 30 | 100.0% | Met 95% WHO based target |

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

| Findings |
|--|
| At the inspection in October 2019 the practice was rated as requires improvement for working age people (including those recently retired and students) due to their cervical screening uptake over previous year being 64.8% and below the 70% national uptake. |
| At this inspection we found that the uptake rate was 62.4% and lower than the last inspection and was still below 70% and 80% England target. |
| The practice was aware that the cervical screening uptake rate was below the national average and opportunistic screening took place and a pop-up icon was in place on the patients record to highlight to reception staff that an appointment was required. They had continued to offer this service during Covid19 and made every effort to encourage patients to attend for an appointment. Cervical screening events were organised across Spirit Healthcare Limited GP practices. Women were offered flexible appointments to fit around their schedules. There was a cervical smear protocol in place, but it was not dated and did not have a version control |

| Cancer Indicators | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------|
| The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/12/2020) (Public Health England) | 62.4% | N/A | 80% Target | Below 70% uptake |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE) | 66.4% | 62.2% | 70.1% | N/A |
| Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2019 to 31/03/2020) (PHE) | 46.4% | N/A | 63.8% | N/A |

| | | | | |
|---|--------|-------|-------|--------------------------|
| The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF) | 100.0% | 92.1% | 92.7% | N/A |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE) | 56.5% | 53.4% | 54.2% | No statistical variation |

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

| Variation Bands | Z-score threshold |
|--------------------------------------|------------------------|
| Significant variation (positive) | ≤ -3 |
| Variation (positive) | > -3 and ≤ -2 |
| Tending towards variation (positive) | > -2 and ≤ -1.5 |
| No statistical variation | < 1.5 and > -1.5 |
| Tending towards variation (negative) | ≥ 1.5 and < 2 |
| Variation (negative) | ≥ 2 and < 3 |
| Significant variation (negative) | ≥ 3 |

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **PHE:** Public Health England.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.

- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)).
- ‰ = per thousand.