Care Quality Commission

Inspection Evidence Table

Water Eaton Health Centre (1-5025253959)

Inspection date: 5 February 2019

Date of data download: 04 February 2019

At our previous inspection on 2 October 2018, we rated the practice as inadequate for providing safe services and this rating will remain unchanged until we carry out a further full comprehensive inspection within six months of publication of the report from October 2018.

- **Systems to keep people safe and safeguarded from abuse required strengthening. The practice was unable to provide assurance to support that appropriate safety systems were in place to safeguard vulnerable adults and children.**
- **Recruitment procedures did not provide assurance that staff had suitable skills and experience for their role.**
- **Appropriate background checks had not been undertaken for all staff and resulting risks to patient safety had not been assessed.**
- **Risks to patients and staff had not adequately been assessed, in particular with regard to staff training.**
- **Systems for managing safety incidents were lacking. Processes for managing significant events were inconsistent and did not offer assurance that appropriate action had been taken in response to concerns identified. Evidence of shared learning and improved safety as a result of complaints, significant events and external safety alerts was not demonstrated.**

These arrangements had improved when we undertook a follow up inspection on 5 February 2019. The practice had taken effective action to comply with the warning notice.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y

Safeguarding	Y/N/Partial
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Y
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y

Explanation of any answers and additional evidence:

During our inspection in October 2018 we found:

- The practice did not have appropriate systems to safeguard children and vulnerable adults from abuse. One clinical member of staff had not updated their training for safeguarding children to a level appropriate to their role. Learning from safeguarding incidents was not available to staff. We found that records of safeguarding concerns were not accurately maintained and that minutes from safeguarding meetings were not kept. The practice did not maintain registers of children identified as at risk. During our inspection in February 2019 we found the practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff had now received up-to-date safeguarding training appropriate to their role. Registers of vulnerable children and adults were maintained and evidence to support regular multi-disciplinary safeguarding meetings were undertaken was available.

- Staff who acted as chaperones were trained for their role however, not all had received a Disclosure and Barring Service (DBS) check. (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.) In February 2019 we saw DBS checks had been undertaken for all staff requiring them.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE)	Y

guidance and if relevant to role.	
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff had any necessary medical indemnity insurance.	Y

Explanation of any answers and additional evidence:

During our inspection in October 2018 we found:

- The practice did not consistently undertake appropriate staff checks at the time of recruitment or on an ongoing basis. Evidence to support staff competencies and qualifications both prior to employment and on an ongoing basis was also lacking. In February 2019 we saw the practice had improved systems for managing staff records and developed protocols to ensure appropriate staff checks were undertaken prior to commencement of employment and on an ongoing basis.
- A system to manage infection prevention and control had been developed but staff records of vaccinations were incomplete. At our inspection in February 2019, the practice had successfully undertaken a comprehensive review of all staff immunity status and records for all staff were maintained.

During our inspection in February 2019 we noted the practice had a paper based system for monitoring clinical staff registration and medical indemnity insurance renewal dates. On the day of inspection, we found the indemnity certificate for one member of staff was out of date. The practice submitted evidence following inspection to demonstrate appropriate insurance was in place. In response to feedback on the day of inspection the practice advised they would be transferring to an electronic system to reduce identified risks.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y

Explanation of any answers and additional evidence:

During our inspection in October 2018 we found that the practice did not have records to demonstrate regular effective engagement with other agencies to reduce the risks to patients, particularly in relation to safeguarding. The practice had improved its meeting structures and we saw evidence of regular engagement in multi-disciplinary meetings where needed. For example, we saw safeguarding meetings were held every six weeks with the health visitors. Minutes were maintained and patient records updated where needed.

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation.

Medicines management	Y/N/Partial
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Explanation of any answers and additional evidence: During our inspection in October 2018 we found systems for managing the security of blank prescription forms needed strengthening. Immediately following our inspection, we were sent evidence that the practice had amended their protocol for prescription handling to reduce identified risks. We reviewed this new protocol during our inspection in February 2019 and found it had been embedded into the practice effectively.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial
Number of events reviewed:	Two
Number of events that required action:	Two
Explanation of any answers and additional evidence: During our inspection in October 2018, we found the practice did not have a systematic approach to handling significant events and records were not appropriately maintained. The protocol for handling significant events had been updated and there was evidence to support significant events were now actioned appropriately and in line with the protocol. Although we were told significant events were discussed in practice meetings we did not see evidence of this in the minutes of meetings we reviewed. The practice advised that they would ensure significant events were added as a standing item on the agenda for practice meetings in the future.	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y

Explanation of any answers and additional evidence:

Following our inspection in October 2018, the practice had expanded its policy for handling safety alerts to ensure a log of safety alerts received and actions taken was maintained. We saw during our inspection in February 2019, that this expansion to practice policy had been effectively embedded.

Effective

At our previous inspection on 2 October 2018, we rated the practice and all of the population groups as inadequate for providing effective services overall because systems to ensure staff received appropriate training were lacking. This rating will remain unchanged until we carry out a further full comprehensive inspection within six months of publication of the report from October 2018.

These arrangements had improved when we undertook a follow up inspection on 5 February 2019. The practice had taken effective action to comply with the warning notice.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

During our inspection in October 2018 we found:

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews. However, we found that the practice had not sought assurance of these competencies for all appropriate staff prior to employment. In February 2019 we found the practice had improved its recruitment processes to ensure assurances were sought for all appropriate staff prior to employment.
- Not all staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date. All clinical staff training was now up to date and a system had been developed to maintain oversight of required training schedules in the future.

- The practice provided protected time for staff to undertake learning and training. However, up to date records of skills, qualifications and training were not well maintained. We noted in this inspection that the practice had made considerable efforts to improve record keeping for staff and we saw all mandatory training had been completed. Outstanding peripheral training was appropriately monitored and staff were regularly encouraged to complete all training.

- The practice did not undertake regular appraisals for all staff. During our visit in February 2019, we saw all staff had now received an appraisal where needed and that a schedule of appraisals had been developed.

Responsive

At our previous inspection on 2 October 2018, we rated the practice and all of the population groups as inadequate for providing responsive services overall because:

- **Records maintained in relation to handling of complaints and concerns were inconsistent. Evidence of learning and improvement to the quality of care as a result of complaints was not available.**

These arrangements had improved when we undertook a follow up inspection on 5 February 2019. The practice had taken effective action to comply with the warning notice.

This rating will remain unchanged until we carry out a further full comprehensive inspection within six months of publication of the report from October 2018.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received between September and December 2018.	12
Number of complaints we examined.	Two
Number of complaints we examined that were satisfactorily handled in a timely way.	Two

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Explanation of any answers and additional evidence:

During our inspection in October 2018 we found repeat inconsistencies with complaints handling at the practice. At our inspection in February 2019, we reviewed the complaints policy and actions taken in response to complaints received. We found the process for handling complaints had significantly improved. All complaints we reviewed were handled appropriately and learning and improvements were shared and actioned where required.

Well-led

At our previous inspection on 2 October 2018, we rated the practice as inadequate for providing well-led services because:

- **The practice failed to ensure there was effective governance and leadership at the practice therefore increasing risks to patients and persons employed.**
- **There were ineffective systems to assess the risks presented by unsafe staff as there were not effective checks completed on recruitment or engagement of clinical staff to assess their suitability for the role and mitigate the risks to health, safety and welfare of patients who used the service.**
- **We found that appropriate background checks to mitigate risks associated with working with vulnerable adults and children had not been undertaken for all staff.**
- **Risks associated with infection prevention and control had not been adequately assessed in relation to staff vaccinations and immunity.**
- **The training needs of staff were not assessed and monitored, staff did not receive regular appraisals.**
- **Processes for recording and acting upon significant events were lacking.**
- **Records maintained in relation to handling of complaints and concerns were inconsistent. Evidence of learning and improvement to the quality of care was not available.**
- **The practice failed to establish systems to ensure regular engagement with other services and health care professionals involved in the care of vulnerable patients to ensure the safety and wellbeing of those patients.**
- **A focused approach to quality and sustainability was not demonstrated. Evidence of a structured and established meeting system was not demonstrated. Documentation such as minutes or actions arising out of governance meetings and other practice meetings were not consistently available.**

These arrangements had significantly improved when we undertook a follow up inspection on 5 February 2019. The practice had taken effective action to comply with the warning notice.

This rating will remain unchanged until we carry out a further full comprehensive inspection within six months of publication of the report from October 2018.
Leadership capacity and capability

Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Explanation of any answers and additional evidence: We saw the practice had taken a proactive approach to addressing concerns raised during our inspection in October 2018. All areas noted in the Warning Notices issued had been actioned to reduce risks to patients and staff.	

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y

Explanation of any answers and additional evidence:

During our inspection in October 2018 we found:

- Structures, processes and systems to support good governance and management were not established. In February 2019 we saw the practice had improved processes and developed policies and procedures to support good governance.
- Practice leaders had established some policies, procedures and activities to encourage safety however, evidence that they were monitored and operating effectively was lacking. Risks were identified with regard to safeguarding, staff recruitment, training and infection prevention and control. These risks had now been reduced through effective implementation of improved systems.
- Records of meetings held were inconsistent and evidence of actions taken in response to concerns identified during meetings were lacking. The practice failed to establish systems to ensure regular engagement with other services and health care professionals involved in the care of vulnerable patients to ensure the safety and wellbeing of those patients. In February 2019 we saw the practice had a regular schedule of meetings, minutes were kept and required actions completed and recorded as needed.

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Explanation of any answers and additional evidence:
The practice advised they had sought support from the Milton Keynes Clinical Commissioning Group (CCG) to address some of the concerns identified in the Warning Notices issued. The practice was able to demonstrate marked improvements in practice procedures and protocols developed through integrated working with the CCG.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous

improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: The practice demonstrated significant improvements had been made since our inspection in October 2018. Staff we spoke with advised of their commitment to ensuring the practice continued to develop and improve over time.	

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 practices 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 Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	No statistical variation	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
6	No data	Null

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.
- 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.

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

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.