

Care Quality Commission

Inspection Evidence Table

West Street Surgery (1-540962306)

Inspection date: 27 February 2019

Date of data download: 01 March 2019

Safe

At our previous inspection on 19 September 2019, 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 September 2018.

- The practice had not completed risk assessments for fire or health and safety. For risk assessments that had been completed, such as for legionella, the practice had not completed any remedial actions.
- The practice had ineffective systems to manage risk. When incidents did happen, the practice did not share learning from them or improve their processes.
- There was a lack of oversight of complaints, significant events and safety alerts. This led to a lack of learning from these events.
- Not all staff had completed the required mandatory training. Reception staff had not been trained regarding the 'red flag' symptoms of sepsis.
- There were gaps in the system used for prescribing certain medicines that require additional monitoring. The practice could not provide evidence to assure us that blood test results were always reviewed prior to prescribing.
- There was a delay in dealing with correspondence into the practice.
- Staff immunisations were not recorded for both clinical and non-clinical staff.
- We found gaps in record keeping to support appropriate monitoring of the cold chain, as vaccination fridge temperatures were not consistently recorded.
- There was lack of evidence concerning the cleaning of the building.

These arrangements had improved when we undertook a follow up inspection on 27 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.

Safeguarding	Y/N/Partial
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 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
<p>Explanation of any answers and additional evidence:</p> <p>At the September 2018 inspection we found:</p> <ul style="list-style-type: none"> Staff had not received appropriate training in safeguarding. The practice did not invite all community teams to multi-disciplinary meetings meaning that safeguarding concerns were not always shared appropriately. <p>At the February 2019 inspection we found:</p> <ul style="list-style-type: none"> Most staff had received safeguarding training appropriate to their role. The practice was aware of the staff members that still required training and had plans in place to support this. 	

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) guidance and if relevant to role.	Y
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
<p>Explanation of any answers and additional evidence:</p> <p>At the September 2018 inspection we found:</p> <ul style="list-style-type: none"> There was no record of induction for newly appointed staff. There was no induction programme or assurance that they had received appropriate training or support. The practice did not maintain a record of staff vaccinations. <p>At the February 2019 inspection we found:</p> <ul style="list-style-type: none"> The practice had developed an induction programme. We saw evidence that a new staff member 	

had completed this process.

- The practice maintained a log of staff immunisations. This was included in the induction pack to ensure it was completed for all new staff. The practice offered blood tests and vaccines to those without immunity and recorded if staff declined vaccination.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: December 2018	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: December 2018	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the September 2018 inspection we found:</p> <ul style="list-style-type: none"> • The practice had not completed a fire risk assessment and did not hold a log of fire drills or evidence of learning. • The practice had not completed any health and safety risk assessments. • Actions from a legionella risk assessment that had been completed in August 2018 by an external cleaning agency had not been completed. There was no plan in place to complete these actions that included repair work to water storage units. (Legionella is a term for a bacterium which can contaminate water systems in buildings) <p>At the February 2019 inspection:</p> <ul style="list-style-type: none"> • A fire risk assessment had been completed by an external agency in November 2018. A number of recommendations had been made including removing boxes from a boiler room, changing ventilation grills and updating the smoke detection system. We saw evidence that the practice had begun to act on these recommendations and quotes had been obtained for work needed. • All staff had received up to date fire training. • The practice had completed a health and safety risk assessment and found that the electrical systems needed updating. We saw evidence that an electrician had assessed the building and was booked to complete remedial work. • The practice had updated the health and safety policy in February 2019 to include the completion of regular audit activity. • Most staff had completed health and safety training. The practice was aware of the staff that still needed to complete this and had plans in place to support them, including providing time outside of normal work duties. • We saw evidence that water temperatures were being checked on a regular basis to mitigate the risk of legionella. We saw that an engineer had been to assess the work needed to fix the water storage tanks and was booked to complete remedial work. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the September 2018 inspection we found:</p> <ul style="list-style-type: none"> The practice did not have a designated infection control lead. The practice was using external companies and could not evidence that cleaning had been completed. There was no evidence of a cleaning schedule to ensure all areas of the building had been cleaned. There was not consistent recording of fridge temperatures to support the appropriate monitoring of the cold chain. <p>At the February 2019 inspection we found:</p> <ul style="list-style-type: none"> There was a designated infection control lead who liaised regularly with the external cleaning company. A communication book had been set up to ensure that messages could be passed between the practice and the cleaning agency. A schedule of tasks had been developed to ensure all areas of the building were adequately cleaned. These tasks were signed by the cleaning agency when they had been completed. The practice completed regular checks on the cleaning to ensure it had been adequately completed. The practice recorded the temperature of vaccine fridges daily with a digital logger. This was reviewed daily and a monthly analysis was completed by the infection control lead. All clinical staff had received infection control training. 	

Risks to patients

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

	Y/N/Partial
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the September 2018 inspection we found:</p>	

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| <ul style="list-style-type: none">• Reception staff had not been trained in the identification of patients that may be suffering from sepsis therefore these patients may not have been appropriately escalated to clinicians. | |
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At the February 2019 inspection we found:

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| <ul style="list-style-type: none">• Reception staff had received training around the 'red flag' symptoms of sepsis and reminded of the importance of prioritising and escalating these patients. | |
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Information to deliver safe care and treatment

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

	Y/N/Partial
There was a system to monitor delays in referrals.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the September 2018 inspection we found:</p> <ul style="list-style-type: none">• The system for managing referrals into the practice was inconsistent. We saw that there could be delays of up to two weeks for referrals or letters into the practice to be seen by a GP. <p>At the February 2019 inspection we found:</p> <ul style="list-style-type: none">• The process for correspondence into the practice had been reviewed and streamlined. Duty GPs reviewed all urgent letters and referrals on the day of receipt. Correspondence involving a change of medicines were sent to the practice pharmacist for review. We saw no delays in this process.	

Appropriate and safe use of medicines

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

Medicines management	Y/N/Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the September 2018 inspection we found:</p> <ul style="list-style-type: none">• The system for checking the monitoring of medicines that needed review was not evident. We found that blood test results were regularly not available to the practice prior to prescribing. <p>At the February 2019 inspection we found:</p> <ul style="list-style-type: none">• Systems had been implemented to routinely obtain blood results from local hospitals and community services prior to prescribing medicines that needed additional monitoring. Records we looked at confirmed this process was embedded into practice.• The practice pharmacist reviewed all letters that were received by the practice that involved changes to medicines. We saw no delay in this process.	

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.	Y
Number of events recorded in last 12 months:	8
Number of events that required action:	8
<p>Explanation of any answers and additional evidence:</p> <p>At the September 2018 inspection we found:</p> <ul style="list-style-type: none"> The practice had no systems or processes in place that allowed them to evaluate and improve practices. There was no evidence of learning from significant events and no system of recording these. <p>At the February 2019 inspection:</p> <ul style="list-style-type: none"> The practice had developed a system to record significant events that had been commenced in December 2018. We saw that these were reviewed by practice management and learning was taken. We saw that significant events were discussed regularly at practice meetings and that relevant changes to practice was made. 	

Example(s) of significant events recorded and actions by the practice.

Event	Specific action taken
A young patient was prescribed two inhalers in a month that were unlicensed for use in children. The pharmacist had not identified this at review.	The prescription for the child was changed immediately and the patient's family made aware. The practice had completed an audit to ensure that no other children had also been prescribed this inhaler and there were plans in place to repeat this audit. This was discussed with staff at a clinical meeting.

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
<p>Explanation of any answers and additional evidence:</p> <p>At the September 2018 inspection we found:</p> <ul style="list-style-type: none"> There was no system in place to maintain oversight of safety alerts. Safety alerts were not 	

discussed with staff and actions taken were not logged. However, we checked patient notes and saw that safety alerts were being actioned.

At the February 2019 inspection we found:

- The practice had developed a log of safety alert with recorded actions taken. The clinical pharmacist was involved in completing audits where necessary.
- Safety alerts were a standing agenda item at clinical meetings and we saw evidence that they were being disseminated to staff.
- Clinical records that we looked at showed that safety alerts were being appropriately actioned.

Effective

At our previous inspection on 19 September 2019, we rated the practice as inadequate for providing effective 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 September 2018.

- Staff had not completed training necessary for their roles.
- There was no induction programme in place for newly appointed staff.
- Although multi-disciplinary meetings were held, community teams were not consistently invited to share information.

These arrangements had improved when we undertook a follow up inspection on 27 February 2019. The practice had taken effective action to comply with the warning notice.

Effective staffing

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

	Y/N/Partial
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
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N
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
<p>Explanation of any answers and additional evidence:</p> <p>At the September 2018 inspection we found:</p> <ul style="list-style-type: none"> • The practice had limited oversight of the training needs of staff. Staff had not completed training in fire or safeguarding. Staff told us they were not always allocated time to complete training. • There was no induction process for new staff or evidence of appropriate training or support. 	

- There was no evidence of appraisals or clinical supervision for staff.

At the February 2019 inspection we found:

- The practice had developed a training matrix to give oversight of staff training needs.
- Most of the mandatory training had been completed by staff. The practice was aware of staff members that still needed to complete training and had plans in place to support them with this, including allocating time outside of their daily tasks.
- The practice had completed appraisals for most staff members with dates booked for those that were outstanding. A system of clinical supervision had been developed where competency was assessed for all clinical staff.
- The practice had developed an induction programme for newly appointed staff. Although they did not use the Care Certificate, the induction plan followed the skills described in this framework.

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) <small>(QOF)</small>	Y
Explanation of any answers and additional evidence: At the September 2018 inspection we found: <ul style="list-style-type: none"> • Multi-disciplinary meetings were held however community teams such as health visitors and district nurses were not consistently invited to attend. This led to information not always being shared effectively. At the February 2019 inspection we found: <ul style="list-style-type: none"> • The practice had allocated the task of organising multi-disciplinary meetings to a member of the admin team. We saw evidence that these meetings were better attended by community teams. 	

Responsive

At our previous inspection on 19 September 2019, we rated the practice as inadequate for providing responsive 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 September 2018.

- There was no oversight of complaints and these were not discussed with staff. There was no evidence that the practice was learning from complaints.

These arrangements had improved when we undertook a follow up inspection on 27 February 2019. The practice had taken effective action to comply with the warning notice.

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 December 2018 and February 2019.	10
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the September 2018 inspection we found:</p> <ul style="list-style-type: none"> • There was no oversight of complaints and they were not reviewed. The practice did not discuss complaints with the staff teams or learn from them to improve practice. <p>At the February 2019 inspection we found:</p> <ul style="list-style-type: none"> • The practice had developed a log of complaints in December 2018. We could see evidence that these complaints were responded to in a timely manner. Patients were given information of how to escalate their complaint to the Parliamentary and Health Service Ombudsman within the complaints leaflet and response letters. • Complaints were discussed at clinical meetings and we saw evidence of learning and improvement. 	

Well-led

At our previous inspection on 19 September 2019, we rated the practice as inadequate for providing well-led 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 September 2018.

- Staff told us they felt unsupported and undervalued.
- There was evidence of a lack of communication between staff and management teams.
- Staff told us there was a 'bullying' culture and they felt their concerns were not responded to.

These arrangements had improved when we undertook a follow up inspection on 27 February 2019. The practice had taken effective action to comply with the warning notice.

Culture

The practice was working towards a culture which drove high quality sustainable care.

	Y/N/Partial
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Partial
Explanation of any answers and additional evidence:	
At the September 2018 inspection we found:	
<ul style="list-style-type: none"> • Staff told us they felt unsupported and undervalued in their work. They told us that there was a 'bullying' culture and they did not feel their concerns were listened to. There was evidence of a lack of a cohesive partnership within the management team. • There was evidence of poor communication with staff teams. There were no practice meetings. 	
At the February 2019 inspection we found:	
<ul style="list-style-type: none"> • Clinical staff told us that the culture of the practice had improved. They told us they felt valued and supported. • Regular clinical meetings were held weekly to improve peer support and information sharing. • Reception staff told us that they felt more supported than in previous months however, they still felt undervalued. There were no formal reception meetings held and information from clinical or business meetings was not cascaded to the team as necessary. Staff told us they still felt separate from the rest of the practice. • Staff we spoke with told us that the management team were more supportive and visible. • Staff told us they felt able to raise concerns and were confident they would be responded to. 	

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
Explanation of any answers and additional evidence: At the September 2018 inspection we found: <ul style="list-style-type: none">• There was a lack of governance and oversight of systems. This included a lack of oversight of safety alerts, incidents and complaints. At the February 2019 inspection we found: <ul style="list-style-type: none">• Governance systems had been reviewed and there was oversight of incidents, complaints and safety alerts.• Staff job descriptions had been reviewed and staff told us they were clear about their responsibilities.• Governance and management structures had been reviewed and reorganised.• All areas in the warning notice had been noted and acted upon.	

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 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.