Care Quality Commission

Inspection Evidence Table

Anerley Surgery (1-4224516819)

Inspection date: 29 January 2019

Date of data download: 28 January 2019

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Safe

Safety systems and processes

The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y

Explanation of any answers and additional evidence:

Previous CQC inspection 31 October 2018

At our previous inspection in October 2018 there were no Disclosure and Barring Service (DBS) checks obtained for two members of staff who were undertaking chaperone duties. The practice manager had told us he was in the process of obtaining DBS checks, we were not shown any evidence of this. We had been told these staff members were not undertaking chaperoning duties, only the practice manager or other staff members that had a DBS check had been acting as chaperones. However, when we spoke with one non-clinical staff member they confirmed they had been undertaking chaperone duties and had not had a DBS check.

CQC inspection 29 January 2019

At this inspection we asked which staff members acted as chaperones. We were told the two non-clinical members of staff acted as chaperones. We asked to see staff files and saw both members of staff had DBS checks in place. From the staff files we reviewed, we saw the practice manager did not have an enhanced DBS check. The practice sent us evidence of an application for an enhanced DBS check immediately following the inspection.

Safety systems and records	Y/N/Partial
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 03/01/2019	Y
There was a log of fire drills. Date of last drill: 02/01/19	Y
There was a record of fire alarm checks. Date of last check: 28/01/19	Y
A fire risk assessment had been completed. Date of completion:	P[1]
Actions from fire risk assessment were identified and completed.	N

Explanation of any answers and additional evidence:

Previous CQC inspection 31 October 2018

At the previous inspection, we were told fire drills occurred every three months however these were not documented. After the inspection the practice provided us with evidence of a fire drill policy and a documented fire drill.

CQC inspection 29 January 2019

[1] At this inspection, the fire risk assessment report was incomplete. There was no date recording when the assessment was carried out. There was no practice action plan which clearly identified improvements needed and actions completed. Staff had not followed the fire safety policy to ensure the fire risk assessment was maintained and updated regularly.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: Various, last one 05 December 2018. Updated 02/01/2019.	P
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Various, last one 05 December 2018. Updated 02/01/2019.	P

Explanation of any answers and additional evidence:

At our previous inspection in October 2018, a number of risk assessment documents could not be found.

At this inspection, there was limited evidence the practice had documented actions taken in relation to health and safety and security of the premises. We saw a record of a general risk assessment which included a list of control measures. However, the practice did not have an action plan which clearly identified the improvements needed and those completed.

Risks to patients

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

	Y/N/Partial
Comprehensive risk assessments were carried out for patients.	N
Risk management plans for patients were developed in line with national guidance.	P

Explanation of any answers and additional evidence:

Previous CQC 31 inspection October 2018

At the previous inspection in October 2018 we found gaps in systems to manage risks to patient safety.

a) A number of documents could not be found on the day of the inspection including risk assessments, significant events records and complaints. We were told this was because of an IT issue to do with data migration from June 2018 when the practice moved from one computer system to another. The practice did not monitor and review health and safety risks. They had no clear understanding of risks, and a current picture of safety that would lead to safety improvements.

b) There was no oversight for the use of the computer system. In June 2018 the practice had started using a new electronic patient record system and we found staff could not use it effectively or efficiently. We were told two staff members, the part time nurse and an administrator, were competent in using the new computer system. We found the lead GP and the practice manager relied on other staff who could use the system and were not competent. No risk assessment had been undertaken to acknowledge the impact or risk this posed to patients.

CQC inspection 29 January 2019

At this inspection, we found systems to manage risks had not improved sufficiently. There was a lack of comprehensive risk assessments carried out for patients and risk management plans were not developed effectively, in line with national guidance.

a) Staff were still not able to find risk assessments easily. We saw a record of two significant events and we were able to review the complaints folder. The system of recording safety risk assessments was inadequate. From the risk assessments we reviewed, there was no clear system to record the findings of the risk assessment and no effective risk evaluation. For example, we looked at the fire risk assessment and there were no dates recording when assessments were carried out. There was no prioritisation of fire risks identified. There was no practice action plan which clearly identified improvements needed and actions completed. We looked at the fire action arrangements. The practice had a fire safety policy in place. We saw a log of weekly fire alarm tests. There were designated fire wardens within the practice. We saw a record of annual fire alarm and emergency lighting tests dated 22 January 2019. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises. The practice carried out regular fire drills. We looked at a record of fire drills, we noted one member of staff had been absent on the two previous fire drills. We spoke to the member of staff who told us

where the fire evacuation point was.

We asked to see a record of health and safety risk assessments. We saw a copy of the general risk assessment master template. There was limited evidence that risks were monitored and reviewed. We spoke to the practice manager who told us he carries out a walk round once a week and deals with any hazards identified.

During our inspection, we discussed our concerns about the lack of comprehensive safety risk assessments, with the provider. Following our inspection, the practice sent us a premises risk assessment document which included a record of evaluation of risks identified and the control measures in place to mitigate the risk of harm. The practice also sent us an updated fire safety risk assessment which included an evaluation of existing fire safety provisions at the practice and a timescale for biannual review.

b) At this inspection we spoke to the provider about how they had managed the transition to the new patient record system. There were improvements in the use of the computer system to support the delivery of safe care and treatment. We saw staff performing searches on the patient record system. Staff told us the leaders had engaged with the CCG and had arranged training on the patient record and had looked at other practices locally who use the same system. During working hours, the practice was able to contact Bromley Healthcare IT team for support with the system.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
Explanation of any answers and additional evidence:	

Previous CQC inspection 31 October 2018

a) At our previous inspection in October 2018 there was no evidence of a formal protocol for administrative staff handling letters through the document management system. Staff had previously worked to a verbal protocol, which was not documented.

b) At our previous inspection in October 2018, the system for managing tasks was not effective. We saw 175 tasks dating back to the previous month, which had been sent to the administrator and had not been completed.

c) We looked at patient care plans because there was an issue identified at our previous inspection in October 2018. Asthma management plans had been discussed verbally with the patient and had not been documented on the patient record and there was no record of what the patient was told.

CQC inspection 29 January 2019

a) At this inspection the system for managing tasks had improved. The practice acted effectively on tasks raised on the clinical recording system. Staff actioned and completed tasks in a timely way. The practice had implemented a scanning and workflow protocol for handling letters which included guidance on what documents may be scanned direct to the clinical record without the sight of a clinician. We spoke to staff who were able to explain the process of handling information on the document management system.

b) At this inspection, staff had received training on the practice system. Staff told us they cleared tasks daily. We looked at a print out of tasks completed between 22 January and 29 January which showed tasks were being actioned and cleared daily. We asked the practice manager to do a search of the carers register. We saw that a search had been set up and saw that the number of carers on the register was 31.

c) At this inspection there was evidence care and treatment was delivered according to evidence-based guidelines. The practice had activated asthma action plan templates on the electronic patient record system so that action plans could be printed off and given to all patients who had an asthma management plan agreed. Staff showed us records of asthma reviews from 93 patients on the asthma register. We looked at a sample of asthma reviews for seven patients. All patients were given action plans. One of the seven asthma reviews we looked at had not been recorded using the asthma review template on the system. We saw the asthma review was recorded separately in the patient's notes. We checked a copy of the action plan given to the patient and saw this was completed. We looked at the asthma register and saw 87% of 117 patients had asthma care plans.

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
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
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
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y

Explanation of any answers and additional evidence:

Previous CQC inspection 31 October 2018

a) At our inspection in October 2018, we found the practice had not always been monitoring patients prescribed high risk medicines appropriately. We found the practice was unable to provide evidence that nine patients, whose records we looked at, were correctly monitored prior to prescribing. Patients were prescribed medicines even though the prescribing clinician did not have the blood results necessary to ensure the prescribed dose was correct. These patients were not monitored according to best practice guidelines from National Institute of Health and Care Excellence (NICE).

b) At our inspection in October 2018 we found the practice had no paediatric (child) defibrillator pads and no paediatric pulse oximeter. There were no risk assessments to justify these decisions.

CQC inspection 29 January 2019

a) At this inspection we found the practice had taken steps to improve safe use of medicines. The practice had reviewed medicines management with the Bromley CCG's pharmacy advisors and in November 2018, introduced a protocol to monitor high risk drugs. We saw staff followed the protocol for prescribing of high-risk medicines. There was a written policy on warfarin prescribing. The practice had completed a search of all patients taking high risk medicines to ensure patients were correctly being recalled for monitoring. We saw an example of a letter sent to all patients identified on high-risk medicines, advising that patients who were on medication for conditions which required regular biological testing would only be issued medication if they were up to date with their testing. The practice told us they now included messages in the prescription form for both the patient and the pharmacist about having blood tests prior to receiving prescriptions for high-risk medication.
We looked at 15 patients on high risk medicines and found monitoring was satisfactory. For example, we looked at three patients on methotrexate and saw all patients had received liver function tests. There were 11 patients on warfarin. We looked at four records and found the patients on warfarin had received INR blood tests at the advised interval (International Normalised Ratio (INR) is a measure of how fast the blood clots). There was one patient on Lithium. We looked at their record and saw they had a blood test at the advised interval prior to prescribing.

Medicines management	Y/N/Partial
b) At this inspection we found arrangements for emergencies were adequate. The practice had obtained paediatric defibrillator pads, and these were stored with the defibrillator. At our inspection in October 2018 there was no paediatric pulse oximeter. At this inspection we saw that the practice had obtained a paediatric pulse oximeter.	

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.	P
Staff knew how to identify and report concerns, safety incidents and near misses.	P
There was a system for recording and acting on significant events.	P
Staff understood how to raise concerns and report incidents both internally and externally.	P
There was evidence of learning and dissemination of information.	P
Number of events recorded in last 12 months:	2
Number of events that required action:	2

Explanation of any answers and additional evidence:

Previous CQC inspection 31 October 2018

a) At our previous inspection, a number of documents could not be found on the day of the inspection including risk assessments, significant events records, and complaints. We were told that this was due to another IT issue to do with data migration from Vision to EMIS.

b) The complaint policy and procedures were in line with recognised guidance. We were not able to review the full complaints process, because the practice could not find the full records of acknowledgements, and responses.

CQC inspection 29 January 2019

a) At this inspection there was no comprehensive system for recording and acting on significant events. Records we saw were paper based and reporting was an informal process. Staff were still not able to retrieve records of significant events easily. We saw two records of significant events reported but neither of the report documents had dates on. Following our inspection, the practice sent us amended copies of the two significant event records we reviewed and we saw that the date of each significant event had been added. We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints. Staff we spoke to knew how to identify and report concerns but it was not clear that all staff knew how to identify and report significant events.

b) At this inspection, the system for recording complaints was paper based and written complaints were kept in a folder. Information about how to make a complaint was available on

the practice website. There was a designated responsible person who handled all complaints in the practice. We asked to look at the complaints folder. We saw one written complaint received in October 2018 and we saw this has been responded to appropriately.

We saw a complaints protocol in place; however, staff were not following it. For example, the practice had not recorded verbal complaints and there was no record of changes to procedure or action taken as a result to improve the quality of care. Information about services and how to complain was available in reception. The practice had a limited system for recording feedback from patients. The practice told us they maintained a feedback book on the reception desk which was accessible to patients for their comments.

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

Event	Specific action taken
Patient had not received their usual hypoglycaemic medication from pharmacy when they had gone to collect the medication. Patient missed taking medication for two weeks which could have had health implications.	Significant event discussed factors that led to the event with the GP, the pharmacist and the practice manager. Action taken to reassure patient and check Hba1c to make sure the patient was safe. Discussion on how to improve communication between pharmacy and the practice. Recorded the event on the significant analysis report template.
Patient received more than the requested number of insulin pens from the pharmacy. Potential to have a hypoglycaemic episode if overdosed on insulin.	Patient was contacted about the incident and the practice informed the pharmacist about the incident. Pharmacist agreed to do a medication usage review. Practice agreed to work more closely with pharmacies on the use of regular medication usage reviews in order to identify and prevent further incidents. Recorded the event on the significant analysis report template.

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:

Previous CQC inspection 31 October 2018

At our inspection in October 2018 the practice had ineffective arrangements for managing safety alerts. Staff including the GP were unable to run searches and were unable to efficiently check safety alerts. The practice was not able to respond to alerts promptly. The practice would have to contact the CCG when a search alert came in to the practice and it could take up to 48 hours for a search to be undertaken on behalf of the practice.

CQC inspection 29 January 2019

At this inspection we found arrangements for managing safety alerts had improved. There was a safety alert policy and staff used a central alert system spreadsheet to record the date of searches and action taken. We saw evidence that each alert was searched within the patient record system and recorded on

the spreadsheet. Safety alerts were received by email and checked daily by the practice manager. We asked to see examples of safety alerts. We saw evidence of action in response to the medicine alert in April 2018, on sodium valproate in women of childbearing age. The practice manager told us that safety alerts are distributed to clinical staff. The practice manager told us he printed off copies of the safety alerts and each clinician is given a copy. We saw a folder where paper copies safety alerts are stored and retained as a surgery record.

Well-led

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
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:

Previous CQC inspection 31 October 2018

At our previous inspection, we found;

a) Systems and processes were not fully established and did not operate effectively. There was a lack of oversight of significant events, patient feedback and complaints. There was a lack of formal governance structure in place to ensure priority areas of improvement were highlighted, risks identified, and actions planned. A number of documents could not be found on the day of the inspection including risk assessments, significant events records, and complaints.

b) Leaders did not have a clear understanding of computer systems used to manage and monitor patients. No risk assessment had been undertaken to acknowledge the impact or risk this posed to patients.

c) At the previous inspection, the practice did not have an effective system in place to monitor patients on high risk medicines

d) The system for managing safety alerts was ineffective. We were told by the practice manager it could take up to 48 hours to process as the CCG needed to be contacted to carry out searches on the patient recording system.

e) At this inspection we looked at asthma review records. Since our previous inspection, the provider had worked with Bromley Healthcare IT support and activated the asthma action plan template on the new electronic patient record system. Following our previous inspection, the provider told us 87% of 117 patients on asthma management plans had been reviewed and given asthma action plans.

f) There was no oversight for managing tasks sent to the administrator through the document managing system. On the day of the inspection we noted 175 tasks had been sent to the administrator dating back to September 2018, none of these had been completed 10 had been actioned.

g) There were no written protocols for staff dealing with letters that came into the practice, though all staff we spoke with knew what the process was. Practice leaders had established some policies, procedures and activities to ensure safety, but there was a lack of oversight and they could not assure themselves that they were operating as intended.

h) At the previous inspection, the provider had not ensured all appropriate staff had had a DBS check.

CQC inspection 29 January 2019

a) At this inspection, we saw a record of significant events. Staff were still not able to find record of significant events easily. There was no formal process for recording significant events. It was not clear that staff were able to identify what was a significant or adverse event. There were no records of minutes from November or December 2018.

We saw the complaints policy. It was not clear that staff were following the protocol for handling complaints. Staff told us they did not routinely document verbal complaints from patients.

b) There were improvements in the use of the computer system to support the delivery of safe care and treatment. Staff told us the leaders had engaged with the CCG and had arranged training on the patient record and had looked at other practices locally who use the same system.

c) At this inspection we found suitable arrangements suitable systems in operation to monitor patients on high risk medicines.

d) There were suitable systems to manage safety alerts. For example, safety alerts were checked daily by staff and documented on a central alert spreadsheet and the appropriate action was taken and recorded.

e) At this inspection we looked at asthma review records. Since our previous inspection, the provider had worked with Bromley Healthcare IT support and activated the asthma action plan template on the new electronic patient record system. Following our previous inspection, the provider told us 87% of 117 patients on asthma management plans had been reviewed and given asthma action plans.

f) At this inspection we looked at the system for managing tasks. We looked at a print out of tasks completed on the document management system between 22 January and 29 January which showed tasks were being actioned and cleared daily.

g) There were written protocols for staff dealing with letters that came into the practice. Staff we spoke with knew what the process was. Practice leaders had established document handling procedures and activities to ensure safety.

h) There was a system to ensure Disclosure and barring service (DBS) checks in place for appropriate staff. We looked at DBS for three members of staff. Staff who acted as chaperones were trained for their role and had received a DBS check. However, the practice manager did not have an enhanced DBS but sent us evidence of an application for an enhanced DBS check immediately following the inspection.

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
When considering service developments or changes, the impact on quality and sustainability was assessed.	N

Explanation of any answers and additional evidence:

Previous inspection October 2018

At our previous inspection, there were unclear and ineffective processes for managing risks, issues and performance;

a) Practice leaders said they had oversight of safety alerts, serious events and complaints, however the system used to manage these was not effective. The leaders were unable to run searches on the system and relied upon the CCG's support for this, which could take up to 48 hours. We were told complaints and significant events records could not be found.

b) There were ineffective processes to identify, understand, monitor and address current and future risks including risks to patient safety. For example, there was no oversight for not having a paediatric pulse oximeter, or child defibrillator pads and risk assessments had not been undertaken for not having these.

c) We were told fire drills occurred every three months however these were not documented. After the inspection the practice provided us with evidence of a fire drill policy and a documented fire drill.

d) The practice did not have an effective system in place to monitor patients on high risk medicines.

CQC inspection January 2019

At this inspection, processes for managing risks, issues and performance had not improved sufficiently. leaders could not demonstrate there was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety;

a) The system to manage safety alerts had improved. However, the system to manage serious events and complaints remained ineffective.

b) The system of recording safety risk assessments was inadequate. From the risk assessments we reviewed, there was no clear system to record the findings of the risk assessment and no effective risk evaluation. There was minimal evidence that actions from the fire risk assessment were identified and followed up. Leaders had not ensured staff followed the fire safety policy to ensure the fire risk assessment was maintained and updated regularly.

c) Following our inspection in October 2018, the practice had obtained a paediatric pulse oximeter and child defibrillator pads.

d) The practice had an effective system in place to monitor patients on high risk medicines.

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.