

# Care Quality Commission

## Inspection Evidence Table

### Cranleigh Gardens Medical Centre (1-569891316)

Inspection date: 10 April 2019

Date of data download: 09 April 2019

## Overall rating: Good

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

## Safe

## Rating: Good

### 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
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:	
At our previous inspection (December 2018) we issued a requirement notice for Regulation 13 HSCA	

<b>Safeguarding</b>	<b>Y/N/Partial</b>
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(RA) Regulations 2014: Safeguarding service users from abuse and improper treatment. This was because the practice was unable to demonstrate clinical staff had undertaken the correct level of safeguarding vulnerable adults from abuse training and practice staff had not undertaken Prevent training. (Prevent is the national term for prevention of radicalisation).

At this inspection we found:

- Clinical staff had undertaken level 2 safeguarding adults training. Since our previous inspection national guidance had changed and we saw documented evidence to demonstrate Level 3 training for all clinicians was available on the practice e-learning system from May 2019. We saw evidence the practice had attempted to resource this training elsewhere prior to availability via e-learning.
- One GP had face to face level 3 safeguarding training booked and there was a plan to cascade this to clinical staff. A decision had been made that all clinical staff would receive level 3 training for assurance around management of safeguarding concerns and record keeping (which was above the expected training for their role).
- The practice had made the decision to train all non-clinical staff to level 2 safeguarding children and this had been achieved.
- Staff had completed Prevent training with clinicians completing level 3 training. Reception staff had easy access to a brief guide on Prevent.
- To ensure the correct level of understanding of safeguarding was embedded, staff had completed a quiz about safeguarding such as safeguarding definitions and principles, practice policy and process.
- All staff were up to date with Mental Capacity Act training. Domestic violence and abuse training had been provided for staff along with other training for vulnerable groups such as Deprivation of Liberty safeguards (DoLs), learning disability awareness, dementia and end of life care.

The practice had good processes to manage patients at risk of or suffering from abuse:

- The practice had a 'concerns list' which enabled all to staff to add patients if they had concerns. These patients were discussed at the bi-monthly safeguarding meetings and if necessary were added to registers for vulnerable patients or those at risk of or experiencing abuse.
- The practice had a 'under the radar' register for those children who may be in need of extra support or for families where there were additional concerns regarding health and wellbeing.

Previously we asked the practice to review the administration of safeguarding meetings. We reviewed minutes from safeguarding meetings and found actions and the person tasked with actions were recorded within the minutes. The minutes including actions and outcomes were fully documented within patient records.

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Since our previous visit the practice had implemented an annual appraisal system for salaried GPs and a formal monthly clinical supervision system for nursing staff.</li> <li>• All staff had a complete immunisation record. The practice had ensured that staff who were out of date with vaccination against infectious diseases had received updates.</li> </ul>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: June 2018	Y
There was a record of equipment calibration. Date of last calibration: October 2018	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: February 2019	Y
There was a log of fire drills. Date of last drill: September 2018	Y
There was a record of fire alarm checks. Date of last check: Weekly	Y
There was a record of fire training for staff. Date of last training: March 2019	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: December 2014	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice had an external company that provided documentation required for health and safety. This included advise in-line with the Health and Safety Executive around PAT testing. The</li> </ul>	

practice had a risk assessment for PAT testing which they reviewed annually.

- Fire extinguisher checks underwent an external annual assessment. A weekly check, including checks for emergency lighting, fire alarm testing and other fire equipment was in place.
- Fire drills were undertaken six-monthly. The practice demonstrated a fire drill was planned the following week. At the branch surgery there was clear additional training for staff in the procedures to follow in case of fire.
- Fire training was provided through the practice's e-learning system. In addition, all staff had received annual face to face training in March 2019.
- An initial fire risk assessment was completed in 2014. The practice undertook annual reviews of the assessment and any completed actions. In November 2018 Avon and Somerset Fire Service had completed an unannounced visit. They assessed the practice fire safety management as good. Following the assessment, the practice acted to install additional emergency exit signs.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: November 2018	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: November 2018	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice had named clinical and non-clinical leads for health and safety.</li> <li>• All staff had undertaken health and safety training.</li> <li>• The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, electrical wiring testing and legionella (Legionella is a term for a bacterium which can contaminate water systems in buildings). Weekly processes were in place to reduce Legionella risk.</li> </ul>	

## 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
Date of last infection prevention and control audit: June 2018	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• All clinical staff had protected time following each session to clean equipment. Following implementation of new recording systems for individual room cleaning, an audit was undertaken to demonstrate compliance. Education sessions were used to stress importance of the room cleaning schedule and recording of completion of the task. The audit cycle was repeated a month later and showed significant improvement in compliance.</li><li>• Actions from the infection prevention and control audit had been completed. For example, hand washing posters had been updated in key areas and a cleaning schedule for the emergency trolley was in place.</li><li>• The practice contracted a cleaning company to clean the premises. Cleaning schedules were maintained and checked by the provider.</li></ul>	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
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
There was equipment available to enable assessment of patients with presumed sepsis or	Y

other clinical emergency.	
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice had undertaken a quality improvement project around Sepsis identification and management in response to changes in national guidance. This included presentations to clinical staff regarding identification and management of suspected sepsis. They introduced useful identification tools for quick reference including laminated NEWS2 scoring charts and desktop links to the Sepsis UK website for guidance for at risk groups.</li> <li>In March 2019 practice staff had undertaken a cardiopulmonary resuscitation (CPR) update.</li> </ul>	

## 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
<p>Since our previous inspection the practice reviewed the way they identified and supported carers:</p> <ul style="list-style-type: none"> <li>They had identified 29 more patients with a carers role (1% of practice population identified as carers).</li> <li>Two additional receptionists had been appointed as carers champions and were booked on a carers workshop.</li> <li>Carers awareness training had been provided to practice staff.</li> <li>The practice newsletter had information on local and national carers support services and detailed how the practice could support carers.</li> <li>The practice was working with the patient participation group (PPG) to engage with patients at practice events to help identify carers and the new PPG chair was a carer.</li> </ul>	
Previously we asked the practice to take action to review and improve uptake rates for cervical screening.	

During this inspection, we reviewed current data for cervical smears as data for 2017/18 (below) showed the practice was below the 80% Public Health England target for national screening and in line with national averages:

- Of the 2,425 patients eligible for screening 2,085 had been screened (85% of eligible patients).
- Staff whose role included taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice had failsafe systems in place to encourage patients to attend screening such as alerts on patient records when a smear was due and additional invitation letters when patients did not book appointments.

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) (01/04/2017 to 31/03/2018) (Public Health England)	73.3%	73.9%	71.7%	No statistical variation

## Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2018 to 31/12/2018) (NHS Business Service Authority - NHSBSA)	0.79	0.88	0.91	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2018 to 31/12/2018) (NHSBSA)	4.0%	4.7%	8.7%	Variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2018 to 31/12/2018) (NHSBSA)	5.70	5.82	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/07/2018 to 31/12/2018) (NHSBSA)	2.43	2.36	2.13	No statistical variation



Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
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
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Nurse practitioners had documented monthly supervision which included a regular review of prescribing for non-medical prescribers.</p>	



## 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• New significant events and incidents were discussed during the daily huddle, documented and accessible to staff not in attendance.</li> <li>• All significant events were discussed at partner meetings. Any learning and actions were shared within practice meetings and where necessary the clinical commissioning group and local GP practices.</li> <li>• An annual review of all significant events took place. We saw the agenda for the April 2019 annual review which included a synopsis of each event, a review of actions taken and lessons learnt.</li> </ul>	

### Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Cold Chain event	<p>The practice experienced an interruption of the electricity supply to the surgery over a weekend. This meant the efficacy of the vaccines could not be assured.</p> <p>We saw the practice followed national guidance for reporting of the incident as well as following the practice's emergency procedures and business continuity plan. As a result, the correct action had been taken and practice procedures for the unexpected event had worked.</p> <p>(The 'cold chain' is a term used to describe the cold temperature conditions in which certain products such as vaccines need to be kept during storage).</p>
Delayed emergency ambulance	<p>Following a delay in an emergency response from the ambulance service in which a person was seriously unwell, the practice invited the head of the ambulance Trust to the practice to discuss the incident.</p> <p>The practice amended its emergency policy: when a clinician</p>

	<p>phones for an emergency response a mobile phone number is provided to the ambulance service which enables paramedics to call the clinician directly. This reduced delays such as accessing the main phone or a clinician not disturbed as they were with a patient.</p> <p>They reviewed the emergency equipment held at the practice and as a result increased the stock of intravenous fluid equipment.</p>
Lapse of practice nurse registration	<p>One practice nurse had problems when renewing their registration to practice and were unaware the registration had not been renewed. The practice took the appropriate action as they stopped the nurse from seeing patients. The practice reviewed and recorded dates of registration renewal for all clinicians. To prevent the issue from arising again administrative staff tasked with quarterly checks to establish if re-registration or revalidation is due to expire.</p>

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> <ul style="list-style-type: none"> <li>The practice had a system to disseminate and record safety alerts. Since our previous visit the system had been updated to record the person with responsibility for managing the alert and any action taken.</li> <li>To ensure safety and medicines alerts were not missed the practice had increased the number of staff receiving the alerts. In addition, as a failsafe, a weekly reminder was in place to check new alerts within the NHS central alert system.</li> <li>We reviewed three recent alerts and found they had been recorded and actioned appropriately.</li> </ul>	

## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.
- 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 weightings 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.