

Care Quality Commission

Inspection Evidence Table

Upton Road Surgery (1-1577808904)

Inspection date: 9 May 2019

Date of data download: 25 April 2019

At our previous inspection on 12 December 2018, we rated the practice as inadequate for providing safe and 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 December 2018.

We rated the practice as inadequate for providing safe services because:

- The practice did not have clear systems and processes to keep patients safe.
- Staff were not being safely recruited.
- The practice did not have appropriate systems in place for the safe management of medicines.
- The practice did not learn and make improvements when things went wrong.
- The premises were not safe and suitable for staff, patients and visitors to use.

We rated the practice as inadequate for providing well-led services because:

- There was no clear governance structure in place at the practice. Roles and responsibilities were not clearly defined. Leaders could not show that they had the capacity and skills to deliver high quality, sustainable care.
- The practice lacked a clear vision and there was no credible strategy in place.
- The practice culture did not effectively support high quality sustainable care.
- The overall governance arrangements were ineffective.
- The practice did not have clear and effective processes for managing risks, issues and performance.
- The practice did not always act on appropriate and accurate information.
- We saw little evidence of systems and processes for learning, continuous improvement and innovation.

These arrangements had improved when we undertook a follow up inspection on 9 May 2019. The practice had taken effective action to comply with the warning notice.

Safe

Safety systems and processes

The practice had improved the 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).	P
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
<p>Explanation of any answers and additional evidence:</p> <p>During our inspection in December 2018 we found:</p> <ul style="list-style-type: none"> Although there was a safeguarding lead in place at the practice, the office manager and staff we spoke with were not aware of who this was. This lead role was not clearly defined at the practice and staff were unclear about who they would approach with any safeguarding concerns. During our inspection in May 2019 we found the practice had reinforced the safeguarding leadership structure during a staff meeting in February 2019. Staff we spoke with were able to identify the person they would approach with any safeguarding concerns. The practice was acting to implement the recently revised intercollegiate guidance 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' to ensure practice nurses met the revised training requirements from level 2 to level 3. We found that staff had been acting as chaperones without the required training. During our inspection in May 2019 we found staff that acted as chaperones had been trained. 	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> Two staff members had not been subject to the required Disclosure and Barring Service (DBS) checks and one of these staff members had been acting as a chaperone without the checks and without any safeguarding training. This staff member had also been working in the service for inclusive healthcare for homeless and marginalised groups without a DBS check or any safeguarding training. <p>During our inspection in May 2019 we found staff had received a disclosure and barring (DBS) check where relevant. Staff that acted as chaperones had been trained.</p>	

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.	P
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: During our inspection in December 2018 we found:</p> <ul style="list-style-type: none"> There were no systems in place to ensure that staff had the required recruitment checks completed on them. We found staff who had not had the required references submitted for them, two staff members who had commenced work without the required Disclosure and Barring Service (DBS) checks and gaps in employment history. During our inspection in May 2019 we found recruitment was now managed through a new policy and recent recruitments had been checked for compliance. There was no system in place to ensure staff vaccination was maintained in line with current Public Health England (PHE) guidance as there was no oversight of this at the practice. We asked to see the policy in place in relation to staff immunisations three times during our inspection. No policy was made available to us. During our inspection in May 2019 we found the practice had reviewed the immunisation status of applicable employees and maintained a spreadsheet. This was work in progress and were expected to be completed by 1 June 2019. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 26 September 2018	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: January 2019	Y

Explanation of any answers and additional evidence:

During our inspection in December 2018 we found:

- There was no adequate oversight in relation to the premises. We asked to see evidence of how this was risk assessed on an on-going basis and were told that no such risk assessments took place. The premises were not suitable for the new inclusive healthcare service for the homeless and marginalised groups. Staff we spoke with told us they did not feel safe and the required modifications to the premises had not been made to ensure the safety of staff and patients. Staff could not see patients in the waiting area from the reception desk and staff reported to us that they did not have a safe system to alert people if they needed to. The premises did not provide adequate safety measures for this type of service and posed a risk to staff and patients. During our inspection in May 2019 we found a risk assessment had been completed with adequate safety measures installed to ensure the safety and confidentiality of staff and patients using the service for the homeless and marginalised groups. Staff that worked at this service told us the new improved measures facilitated a better environment for patient care and interaction.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were now evident.

	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: 31 January 2019	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:

During our inspection in December 2018 we found:

- There was no infection control lead across the service and no systems to ensure that regular infection control audits were completed. We asked to see the last infection control audit during our inspection and no such audit was found. Not all staff had received infection control training as part of their induction and staff were unclear as to who to refer any infection control concerns to. We looked at the infection control records in the substance misuse service at the practice and found the records to be empty. We found staff to be unclear as to how they reported any infection control incidents. One incident involving a blood spillage had been recorded in February 2017, however, no follow action or lessons learnt were recorded. During our inspection in May 2019 we found a new infection control policy had been implemented. A nurse from an adjoining practice provided infection control leadership under a local agreement. Following a recent infection control audit several improvements were evident. These included replacement of waiting room chairs and an enhanced spillage kit to clean accidental body fluid spillage.

Appropriate and safe use of medicines

The practice had improved the 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
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>During our inspection in December 2018 we found:</p> <ul style="list-style-type: none"> Blank prescriptions were not being stored securely including overnight. We found blank prescriptions in the Doctors bag and found that prescription numbers were not logged and monitored to ensure they were managed safely. During our inspection in May 2019 we found the practice had introduced a system to log blank computer-generated prescription sheets. Rooms with printers that contained blank prescriptions were locked when not in use. Prescription sheets left within printers were removed and stored securely at the end of the day or at the end of a session as applicable. Pads for handwritten prescriptions (usually carried in the doctor's bag) were logged by each GP. However, we found a small number of surplus prescription pads. The day after the inspection the practice wrote to us to confirm that the surplus pads were awaiting collection by Primary Care Support England (PCSE) for secure destruction. We looked at the safety of storing medicines within the enhanced service for inclusive healthcare for homeless and marginalised groups which the practice had incorporated from 1 October 2018. We found one of the fridges used for storing vaccines and medicines had been recorded at 9.1 degrees, each time the temperature had been checked since 1 November 2018. The protocol for ordering, storing and handling vaccines issued by Public Health England (PHE) states that vaccines should be stored between two and eight degrees, with a mid-range temperature of five degrees being best practice. 9.1 degrees was not within a safe range for the medicines stored in the fridge. There were a number of vaccines being stored which had been administered to patients during this timeframe. There had been no action taken to ensure these vaccines were safely administered. Patients had been put at risk due to this. The cold chain was not being safely managed at the practice. During our inspection in May 2019 we found the practice had replaced the vaccine refrigerator. A cold chain policy had been implemented and staff had been trained in vaccine management. Temperature monitoring was evident as per guidance by PHE. In addition, we saw monthly audits were used to check temperature fluctuations. 	

Track record on safety and lessons learned and improvements made

Improvements had been made to the way the practice learned and made improvements when things went wrong.

Significant events and complaints	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
<p>Explanation of any answers and additional evidence:</p> <p>During our inspection in December 2018 we found:</p> <ul style="list-style-type: none"> We found an inadequate system to be in place for recording and acting on incidents and significant events which took place at the practice. Staff we spoke with were not always clear on where these should be recorded, and we were shown numerous places in which staff thought they were recorded. All of these were hand written records. We were shown an incident book in the enhanced service for inclusive healthcare for homeless and marginalised groups which was empty, and which had pages removed. Staff we spoke with could not locate any records of any incidents or significant events and thought that these may be kept on the computer. However, none of the staff working on the day of our inspection had any access to these records. It was not clear how incidents or significant events would be recorded at the time of our inspection, or where. There was no evidence that incidents or significant events were monitored to look for any trends or patterns. There was no evidence of any learning from these. <p>There was no analysis or oversight of complaints at the practice. Although complaints were looked at and responded to, they were not collated to look for trends and patterns and no learning outcomes were identified as a result of complaints to drive continuous improvement. Systems were introduced to improve this following our inspection, however, these systems were not in place at the time we inspected the practice.</p> <p>During our inspection in May 2019 we found the practice had introduced a system to report log and act on incidents and significant events and complaints which was managed by the deputy practice manager. Events were recorded individually and were accessible to all staff including locum staff on the practice shared computer drive. Incidents and significant events and any learning points were discussed during staff meetings. Any event that needed immediate action were discussed during the daily lunchtime 'Huddle' which was a quick get together of staff available on the premises each day. We were shown examples of recent significant events for example an incident related to the behaviour management of a patient while attending the practice. The practice planned an annual review of all incidents and significant events in June 2019 though this activity was not reflected in the protocol for managing incidents and significant events.</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> <p>During our inspection in December 2018 we found:</p> <ul style="list-style-type: none"> The system for recording and acting on safety alerts did not ensure that all safety alerts were seen and recorded. We raised this with the practice who immediately took steps to tighten the processes around how safety alerts were managed at the practice. During our inspection in May 2019 we found the practice had introduced a revised protocol for managing safety alerts. There was a responsible lead GP. A spreadsheet gave the status of all alerts received since July 2018 which also contained details of actions taken. Safety alerts were discussed during practice meetings. We checked actions taken by the practice in response to three alerts and we found the practice had acted upon these appropriately. For example, the practice had reviewed of patients on a medicine used in epilepsy which could be high risk for women of child bearing age and acted appropriately as per the guidance on the alert. 	

Effective

Monitoring care and treatment

A programme of quality improvement activity and systems to routinely review the effectiveness and appropriateness of the care provided were evident.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	535.6	537.2	537.5
Overall QOF exception reporting (all domains)	4.0%	5.2%	5.8%

	Y/N/Partial
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y

Any additional evidence or comments

Explanation of any answers and additional evidence:

During our inspection in December 2018 we found:

- There was a lack of effective management oversight and we saw no evidence of effective clinical audits during our inspection, despite asking for these. We found no evidence of improvement initiatives as a result of any quality improvement activity. The lack of effective practice management meant that there was little quality monitoring or audit activity at the practice. During our inspection in May 2019 we were shown details of ten clinical audits currently underway. We reviewed three. Two of these (completed in April and May 2019) were two cycle audits. One of these related to the prescribing of high-risk medicines and had resulted in the rationalisation of these prescriptions based on need and appropriate monitoring of patients that received these medicines. Clinical audits were led by a clinician and we saw evidence of discussions with appropriate clinicians of the results and any improvements that may be needed. We also saw evidence of participation in CCG led audits for example antibacterial prescriptions.

Effective staffing

Processes to demonstrate that staff had the skills, knowledge and experience to carry out their roles were evident.

	Y/N/Partial
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	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
Explanation of any answers and additional evidence: During our inspection in December 2018 we found: <ul style="list-style-type: none">Although some staff had received an appraisal in the last 12 months, there was no on-going monitoring of staff performance and staff we spoke with told us that they did not attend regular one to one meeting with their line manager. Staff did say that management were approachable, however, when we asked to see an overview of staff training, this was not made available to us as no such overview existed. We found gaps in staff training and one staff member had not received any training since commencing their employment at the practice in June 2018. The records we looked at were chaotic and the office manager was unable to locate staff training files easily. During our inspection in May 2019 we found the practice had introduced a training matrix that detailed training needs and compliance based on job roles. This matrix showed that mandatory training specified by the practice was current for applicable staff. Clinical staff had received regular appraisals, and we were informed appraisals for non-clinical staff were planned to happen very shortly commencing 16 May 2019. Staff communication had been improved. The GPs and practice management operated an open-door policy for staff communication and daily 'Huddles' around midday to discuss immediate issues. In addition, the practice participated in a half day learning and development day together with an adjoining practice usually during the first Tuesday of each month.	

Consent to care and treatment

The process to obtain consent to care and treatment in line with legislation and guidance were evident.

	Y/N/Partial	
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y	
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y	
Explanation of any answers and additional evidence: During our inspection in December 2018 we found: <ul style="list-style-type: none">• The practice had registered 16 patients from St Anthony's Care Home in Watford, Hertfordshire. None of these patients had given consent to register with the practice and all the registration forms we looked at had not been signed to provide patient consent. We were told that this alignment of the care home to the practice was done as directed by the CCG. This did not remove the requirement for patient consent. Some of these patients may have lacked the mental capacity to agree to a change in their GP. This had not been considered by the practice. We found a lack of evidence in terms of how mental capacity was considered at the practice by clinicians and staff. There was a lack of understanding of this across the practice and improvement was needed in understanding and requiring the legal requirements in relation to consent and mental capacity.• During our inspection in May 2019 we found the practice had taken steps to ensure affected patients or their legal representatives had consented to the transfer of care from their previous provider. We saw evidence that practice staff had completed an in-house training on the legal reasons why consent should be sought prior to having any patient join the practice or have a procedure done.		

Well-led

Governance arrangements

There were responsibilities, roles and systems of accountability to support good governance and management, but permanent arrangements were being developed.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	P
Staff were clear about their roles and responsibilities.	P
Explanation of any answers and additional evidence:	
<p>During our inspection in December 2018 we found:</p> <ul style="list-style-type: none"> There was no governance structure in place and when we asked to see any audits carried out we were told that there were none to see. The provider did not have systems and structures in place to ensure that the quality of care and treatment was being assessed on an on-going basis. Roles and responsibilities were not clearly defined which meant that information was recorded but that no analysis or learning happened as a result. There was no evidence of the practice understanding their risks and no evidence of continuous improvement. <p>During our inspection in May 2019 we found the practice had taken steps to improve governance structures. Lead roles had been defined. Meetings were formalised, and policies and procedures we reviewed had been updated. Permanent management arrangements were still being formalised. In the interim a consultancy company was assisting the practice to establish leadership and management systems and providing day to day steer. The registered manager told us that the practice was working with the CCG to explore the possibility of merging with the nearby practice based on the upper floor of the practice building.</p> <p>We found systems for understanding risks and learning from significant events incidents and complaints had been refocused and these were now regularly reviewed and acted upon.</p>	

Managing risks, issues and performance

Effective processes for managing risks, issues and performance were evident.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Explanation of any answers and additional evidence:	
<p>During our inspection in December 2018 we found:</p> <ul style="list-style-type: none"> Due to ineffective management and governance at the practice there was no oversight of risk. No risk register was in place and there was no effective monitoring of staff performance on an on-going basis. The office manager and provider were not clear on staff training needs across the 	

practice as a whole and staff had been transferred from another service without an audit of their performance, training and recruitment needs. Changes had been implemented at the practice without adequate planning and risk assessing by the provider and this had impacted on the quality of care and treatment across the practice as a whole.

During our inspection in May 2019 we found the practice had undertaken premises/security and health and safety and other risk assessments. Identified risks were recorded in the practice risk register with specific actions highlighted. Training needs of staff had been reviewed and records of staff mandatory training (as specified by the practice) were now maintained. The practice told us that lessons had been learnt with the transfer of the enhanced service for inclusive healthcare for homeless and marginalised groups and the care homes realignment project and appropriate actions had been taken to mitigate the risks that had arisen.

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- 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.