

Care Quality Commission

Inspection Evidence Table

Husbands Bosworth Surgery (1-4544111311)

Inspection date: 21 November 2019

Date of data download: 26 November 2019

Overall rating: Good

The practice was rated as requires improvement overall and in the safe and well-led key questions at the last inspection in August 2018. This was because the practice was unable to demonstrate that systems in place relating to the safe handling and storage of medicines were effective, or that the dispensary at the practice was safe.

We carried out an inspection in December 2018 to follow-up on warning notices that were issued as a result of concerns that were identified at the previous inspection. The practice demonstrated that they were compliant with the warning notices and systems had been reviewed and updated in order to ensure that risks identified were mitigated.

At this inspection, the practice demonstrated that they had addressed the issues that were identified, and we found no further concerns overall. The practice was rated as good for providing safe and well-led services at this inspection and therefore good overall, as ratings of good for the effective, caring and responsive key questions were aggregated from the previous report.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Safe

Rating: Good

At the previous inspection, the practice was rated as requires improvement because systems in place to ensure mitigation of risk to patients and the safe handling and storage of medicines were not fully effective.

At this inspection, the practice demonstrated that it had taken action to address these issues and we found that systems in place were working effectively and as intended.

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 which were accessible to all staff.	Y

Safeguarding	Y/N/Partial
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	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: N/A	

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 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
Explanation of any answers and additional evidence: The practice demonstrated that they had embedded a comprehensive induction system for new staff. Although the practice assured us that this included local safeguarding procedures, this was not formally documented. Staff we spoke with were knowledgeable about where to find information for the local safeguarding teams and staff files we viewed confirmed that all staff were appropriately trained.	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: August 2019	Y
There was a record of equipment calibration. Date of last calibration: October 2019	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: August 219	Y

There was a log of fire drills. Date of last drill: January 2019	Y
There was a record of fire alarm checks. Date of last check: January 2019	Y
There was a record of fire training for staff. Date of last training: Various dates	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: August 2019	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: N/A	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: May 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: October 2019	Y
Explanation of any answers and additional evidence: The practice demonstrated that they conducted an internal health and safety risk assessment in June 2019 as well as getting an external company to conduct a separate risk assessment in October 2019.	

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
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: July 2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: N/A	

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
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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
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> <p>The practice showed us that a community defibrillator was available at the Welford village hall, where patients could attend on Thursday mornings. The practice was unable to demonstrate that they had considered how long it would take to access this in an emergency however. All other risks had been comprehensively assessed and documented. At the main site all emergency equipment and medicines were present; stored and monitored appropriately.</p>	

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 and 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
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	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: N/A	

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) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.96	0.84	0.87	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). (01/10/2018 to 30/09/2019) (NHSBSA)	13.1%	10.1%	8.5%	Tending towards variation (negative)
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 (01/04/2019 to 30/09/2019) (NHSBSA)	6.44	5.19	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	3.49	2.30	2.08	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	Y

Medicines management	Y/N/Partial
of structured medicines reviews for patients on repeat medicines.	
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.	Y
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
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>The practice were aware of their higher than average prescribing of some antibiotics and demonstrated that they were working with the Clinical Commissioning group (CCG) pharmacist to address this. The practice had an antibiotic guardian and clinicians we spoke with were aware of prescribing guidelines in relation to these medicines.</p> <p>The practice demonstrated that prescriptions were kept securely and monitored appropriately, including blank prescriptions.</p> <p>Systems in place to ensure controlled drugs were received, stored, dispensed and destroyed appropriately were working as intended and effective. The practice demonstrated that they had clear arrangements for raising concerns with the accountable officer and staff we spoke with were aware of these.</p> <p>All appropriate emergency medicines and equipment were available at the practice, these were kept in one location, in the clean utility room. All clinical rooms contained anaphylactic kits and staff we spoke with knew where to find these items. There was a clear system to ensure that these were monitored, and stock replaced when necessary.</p>	

Medicines management	Y/N/Partial
<p>The practice demonstrated that all medicines that required refrigeration were kept in appropriate refrigerators. The temperature of these were monitored regularly and any concerns raised to the appropriate authorities. Records we viewed confirmed this.</p>	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y
Prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Y
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Y
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y
<p>Explanation of any answers and other comments on dispensary services:</p> <p>The lead GP for the dispensary was based at the practice for consistency of oversight.</p> <p>We saw that standard operating procedures were in place and operating as intended. Staff we spoke with were knowledgeable about these.</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
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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:	13
Number of events that required action:	13
Explanation of any answers and additional evidence: The practice had folders, which contained each significant event, current significant events for that month were reviewed at the monthly team meeting. Comprehensive learning points from previous significant events were also reviewed at these meetings to ensure that the practice imbedded the learning. The significant event lead at the practice ensured that subsequent outcomes from significant events are disseminated amongst the team which was done at individual team meeting level to ensure that the system was working.	

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

Event	Specific action taken
Dossett error	In response to an error relating to a medication error, the practice reviewed and updated its protocols to ensure that patients were informed that waiting will be required until dispensary staff had completed their current task and that two staff were present at all times when working on medicine delivery boxes.
Missed referral	In response to a missed referral, the practice reviewed and updated its policy and protocol to ensure that these were monitored and that the patient is asked to call if they have not heard after a week.

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: We looked at several examples of safety alerts and asked the practice to demonstrate what actions they had taken as a result, these were appropriate including searches of and communications with patients where necessary. Examples included, hormone replacement therapy (HRT) medicines and epileptic medicine. We saw that these were also discussed in staff meetings.	

Well-led

Rating: Good

At the previous inspection, the practice was rated as requires improvement for providing well-led services because there was limited oversight of the dispensary.

At this inspection, the practice demonstrated that it had taken action to address these issues and we found that systems in place were working effectively and as intended. The lead for the dispensary worked at the practice for continuity and to ensure that dispensary staff had access to advice at all times.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: N/A	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: N/A	

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
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.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: N/A	

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Staff conversations	Staff we spoke with were happy to work at the practice, understood their role and were clear on the governance arrangements. They told us that the practice was a family and that leaders were supportive.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
Dispensary staff we spoke with were clear on the governance structures and happy with the support they received.	

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	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
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: The practice demonstrated a suite of risk assessments and had taken action where necessary to ensure that patients and staff were safe. The practice conducted their own considerations of risk and also invited external companies to assess risk to ensure that overall risk consideration was more complete.	

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: N/A	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y

Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: The practice engaged with the local community and provided a satellite clinic in the local area. The practice told us that patients liked this and so they continued to provide it, although it was not easily facilitated. The practice provided numerous avenues through which patients could feedback, including family and friends, suggestions box, complaints and surveys.	

Feedback from Patient Participation Group.

Feedback
The patient participation group (PPG) was held every two months to discuss ongoing issues and ideas. They held weekly “meet and greets” with patients at the practice to obtain patient views and feedback. They made suggestions to the practice including implementing the new phone system. They also assisted in installing the new water dispenser when patients brought this up through their feedback. The PPG regularly updated the practice patients about issues effecting the practice in the village newsletter. The PPG chose not to speak with us on the day or following the inspection.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: The practice demonstrated that they provided social prescribing within their Primary Care Network (PCN). The practice had introduced a new Human Resources System that allowed all staff to access their information, including appraisals and training to ensure that transparency was assured. The practice had brought call centre technology into use, by linking all the telephone systems of the two main sites. All calls that came into the practice could be answered by anyone at any of the sites, to ensure that patients were able to access the practice for appointments. A dashboard, detailing call length, number of dropped call and numerous other indicators was monitored by the leadership team. The practice had established a newly qualified nurse scheme in conjunction with a local university to ensure that they were employing a new nurse each year for the first three years. The leadership team demonstrated that they engaged with the apprenticeship scheme to enrich their workforce and develop staff in line with staff development plans and the needs of the business. The practice had engaged in workflow optimisation procedures to ensure that the GPs had access to the	

most relevant information quickly to ensure patients received the most appropriate care and treatment in a timely way.

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. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.
- 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.
- 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). This indicator does not have a CCG average and is scored against the national target of 80%.

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>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

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.