

Care Quality Commission

Inspection Evidence Table

Clinton Road Surgery (1-554425702)

Inspection date: 19 November 2019

Date of data download: 23 October 2019

Overall rating: Good

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

Safe

Rating: Good

Clinton Road Surgery was previously rated as requires improvement for providing safe services. This was because of shortfalls regarding systems to safeguard people from abuse. The practice had undertaken improvements and is now rated as good for providing safe services.

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
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:	
At our last inspection in January 2019 we told that practice that they must establish effective systems	

Safeguarding	Y/N/Partial
<p>and processes to prevent abuse of patients.</p> <p>This was because;</p> <ul style="list-style-type: none"> • Children whose records were coded as having child safeguarding issues did not have easily accessible information prompting authorised clinicians to this risk. • The practice did not have a clear system in place for recording and discussing softer concerns about children who could be at risk. • The practice did not have a consistent approach to recording codes of child protection with assignment of an appropriate risk level. • There was no specific central list of adult safeguarding concerns to provide easily accessible prompts for authorised clinicians alerting them to risks. <p>At this inspection we found that;</p> <ul style="list-style-type: none"> • Safeguarding policies and procedures had been updated which now included different codes for different safeguarding concerns for children, enabling them to be prioritised according to risk. • The practice had implemented safeguarding lists and had designated an administrative safeguarding lead to ensure lists and coding were regularly reviewed and actions from safeguarding multi-disciplinary meetings were added to patient's records and tasked to a clinician if required. • Patient records which documented safeguarding concerns now had 'pop ups' so clinicians were able to identify risks easily. <p>We saw that all staff had completed safeguarding adults training.</p> <ul style="list-style-type: none"> • All staff had completed safeguarding adults and safeguarding children training to the appropriate level for their role. 	

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
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection we told the practice that the following improvements should be made;</p> <ul style="list-style-type: none"> • Review the recruitment process to ensure the 'green book' (The green book has the latest information on vaccines and vaccination procedures, for vaccine preventable infectious diseases in the UK) is adhered to so pre-employment checks include obtaining the immunity status of non-clinical staff. <p>At this inspection we saw that the practice had collated immunisation status for all staff. Staff who were not able to provide proof of immunisation status had agreed to receive blood test and have any relevant immunisation if appropriate.</p>	

Safety systems and records	Y/N/Partial
<p>There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 02/04/2019</p>	Y
<p>There was a record of equipment calibration. Date of last calibration: 11/07/2019</p>	Y
<p>There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.</p>	Y
<p>There was a fire procedure.</p>	Y
<p>There was a record of fire extinguisher checks. Date of last check: 12/10/2019. Last external check 01/07/2019</p>	Y
<p>There was a log of fire drills. Date of last drill: 23/10/2019</p>	Y
<p>There was a record of fire alarm checks. Date of last check: (last serviced by external company 10/01/2018)</p>	Y
<p>There was a record of fire training for staff.</p>	Y
<p>There were fire marshals.</p>	Y
<p>A fire risk assessment had been completed. Date of completion: risk assessment undertaken 08/11/2018 reviewed January 2018</p>	Y
<p>Actions from fire risk assessment were identified and completed.</p>	Y
<p>Explanation of any answers and additional evidence: We saw that the practice's fire alarms had been tested every other month. The practice's fire policy and procedure stated that fire alarms should be tested every week. We spoke to the practice regarding this and they subsequently updated the protocol to ensure fire alarms were tested each week in accordance with their policy and procedure.</p>	

Health and safety	Y/N/Partial
<p>Premises/security risk assessment had been carried out. Date of last assessment: 09/01/2018</p>	Y
<p>Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 09/01/2018</p>	Y

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: December 2018	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: The practice had an infection prevention and control lead. We saw that regular hand washing audits had been completed for all staff.	

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
Explanation of any answers and additional evidence: All staff had completed sepsis training between September 2018 and January 2019.	

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:	

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) (01/07/2018 to 30/06/2019) <small>(NHS Business Service Authority - NHSBSA)</small>	0.77	0.90	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). (01/07/2018 to 30/06/2019) <small>(NHSBSA)</small>	5.7%	9.4%	8.6%	Tending towards 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 (01/01/2019 to 30/06/2019) <small>(NHSBSA)</small>	5.76	5.76	5.63	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) <small>(NHSBSA)</small>	1.94	2.55	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 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	Y

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
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.	N/A
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.	Partial
Explanation of any answers and additional evidence:	
<p>The practice had overview systems to confirm that emergency medicines and equipment were checked each month. Records demonstrated that expiry dates of medicines and stock had been checked each month.</p>	
<p>There was a system in place to check the temperature daily of fridges used to store medicines, to ensure temperatures remained within acceptable parameters. However, we found that fridges had not been checked on eight separate occasions between June 2019 and September 2019. The practice was not able to demonstrate how they assured themselves temperatures had not been outside of recommended parameters on days when temperatures had not been checked. However, we saw that temperatures either side of the missed days were recorded as being within an acceptable range. We discussed this with the practice who told us these had been days when the practice nurse and practice manager were not working at the practice. The practice had subsequently appointed a third staff member to check fridge temperatures on days when the practice manager or practice nurse were not available.</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:	16
Number of events that required action:	16
Explanation of any answers and additional evidence: We saw that positive outcomes were also reported as significant events to encourage and celebrate staff.	

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

Event	Specific action taken
A patient request for a re-referral letter from a consultant had not been picked up by administrator	The practice apologised to the patient and subsequently processed the referral. Managers reiterated to staff what type of post, received by the practice, requires review by the GPs.

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 saw examples of actions taken on recent alerts for example, regarding sodium valproate.	

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)	≤ -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.