

Care Quality Commission

Inspection Evidence Table

Taunton Road Medical Centre (1-554686585)

Inspection date: 8 January 2020

Date of data download: 19 December 2019

Overall rating: Good

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

Safe

Rating: Good

We carried out an announced focused inspection on 8 January 2020 as at our previous inspection on 9 January 2019 we rated Safe as requires improvement due to a breach in Regulation 12 HSCA (RA) Regulations 2014: Safe care and treatment.

At the previous inspection we told the provider they must:

- continue with developing aspects of safe with an oversight of staff's immunisation status, processes for safe medicines management, and aspects of infection control audit.
- continue with monitoring the oversight of patients on high risk long term medications.

We also told they provider they should:

- continue to monitor that the changes implemented for safeguarding adults, recruitment, and disclosure and barring check risk assessments are sustained.
- continue to monitor cervical smear screening to meet Public Health England screening rates.
- continue to proactively identify carers.

During this inspection we reviewed areas where the provider must make improvements identified in our previous inspection in January 2019 and our key lines of enquiry for 'Safe'.

This Evidence Table covers our findings in relation to these. We found the concerns had been resolved when we undertook this inspection.

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

Safeguarding	Y/N/Partial
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
<p>In January 2019 we found:</p> <ul style="list-style-type: none"> The adult safeguarding policy was not detailed and informative as the children's safeguarding policy. For example, it did not include information such as modern slavery, FGM (Female Genital Mutilation) or the referral details for the local authority. Although processes and systems for adult safeguarding kept patients safe it was not to the same standard to those for children. The practice partnership had identified certain staff roles in administration where a Disclosure and Barring Services (DBS) check was not required. However, this was not risk assessed. <p>At this inspection we found:</p> <ul style="list-style-type: none"> The practice had reviewed and updated the system and processes for safeguarding adults. This included a detailed safeguarding adult policy and a monthly structured multidisciplinary meeting to review the vulnerable patients register including those at risk of or suffering from abuse. The practice had an appropriate policy and risk assessment process for determining if a DBS check was necessary. This process identified which job roles would require a DBS check and those that needed a risk assessment. 	

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
Previously (January 2019) we found the practice had commenced seeking information regarding staff's immunisation status. At the time of the inspection they had collated detail of Hepatitis B status only.	

During this inspection we reviewed staff immunisation records: All staff had been asked to complete a record of their immunisations. Where necessary, further action was taken to ensure staff were up to date with routine immunisations. The practice had a process in place to reduce risks to patients and staff when information about staff immunity was not available or staff declined vaccination.

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: August 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: June 2019.	Y
There was a log of fire drills. Date of last drill: August 2019.	Y
There was a record of fire alarm checks. (Annual maintenance and weekly checks in place).	Y
There was a record of fire training for staff.	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

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: January 2019.	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: December 2019.	Y
Full electrical check: September 2019. Lift service: September 2019. Gas certificate: November 2019. Emergency lighting: January 2020. As well as annual maintenance checks the service had a comprehensive range of weekly checks in place. We saw risk assessments were regularly reviewed. For example, new flooring and the risk of slipping following cleaning had been risk assessed. As a result, cleaners were asked to wash floors when the practice was closed to patients to reduce fall risks.	

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.	Y
Date of last infection prevention and control audit: January 2019.	
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
At our previous inspection (January 2019) we found regular room audits did not include all checks that were in line with current guidance for infection control and there was no overall infection control audit across the whole practice. The practice has since reviewed its infection prevention and control (IPC) processes and introduced appropriate checks. We found their annual IPC audit was in line with national guidance. They had also implemented systems to review, discuss and to monitor any actions taken.	

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
The practice undertook an audit to review 10% of each of the GP locums' consultations undertaken at the practice to provide assurance on the quality of care and treatment provided.	

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

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)	0.84	0.85	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)	3.9%	4.7%	8.5%	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 (01/04/2019 to 30/09/2019) (NHSBSA)	5.40	5.99	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)	1.76	2.38	2.08	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
(NHSBSA)				

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.	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
In January 2019 we found: <ul style="list-style-type: none"> Some medicines were not stored securely and were open to the potential of unauthorised access. Vaccine fridges were not locked and keys to fridges could not be found. Medicines stock was monitored in some areas and not in others. 	

Medicines management	Y/N/Partial
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- There was a system to check the emergency medicines and equipment, however we found a small number of needles, syringes and other similar equipment were out of date.
- The practice clinicians had made a decision to not hold a child pulse oximeter (monitor for checking oxygen levels) in line with best practice. No risk assessment had been undertaken to support that decision.
- The emergency medicines kept to respond to medical emergencies was more than the UK resuscitation council guidelines recommendations. No information was available to support this decision making.
- There were gaps in the programme of reviews of the health of patients treated with high risk medicines. In a sample of patient records, we found there was a mixed approach to monitoring patients prescribed these medicines. We found some patients there were delays in reviews and blood tests not being completed before re-issuing repeat prescriptions.

During this inspection, we reviewed the systems and processes for the management of medicines. We found changes had been implemented to rectify our previous concerns. This included:

- An updated medicines management policy and procedure was in place including appropriate regular audits of medicines and equipment.
- Medicines and vaccines were stored appropriately. There was a safe process in place to monitor storage and use of medicines.
- The practice had reviewed emergency medicine stock and monitoring equipment. They had appropriate risk assessments for emergency medicines and had a pulse oximeter suitable for children.
- The practice had developed a prescribing team which included GPs and prescribing clerks, and procedures to support the team. Monthly audits for patients prescribed high risk medicines were undertaken and where necessary patients were contacted and provided with an appointment for blood tests and other monitoring. Appropriate patient reviews were in place as well as systems such as alerts within patient records and prescribing data computerised systems to ensure medicine safety.

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:	43
Number of events that required action:	18
Previously (January 2019) we saw information regarding the number of significant events the practice was unable to demonstrate that appropriate actions had been taken.	
At this inspection we reviewed the practice's significant events processes. We found:	
<ul style="list-style-type: none"> • A dedicated monthly meeting was in place to discuss incidents and events. A record of discussion for each meeting was clear and concise and included actions to mitigate risk if needed. • An annual review of themes and trends took place. • As a result of the practice recognising they did not always receive appropriate information when patients were discharged from other services they introduced and utilised a health professional feedback tool when incidents occurred. For example, a change in a patient's medicines by a hospital consultant and no information detailing this was sent to the practice would result in feedback to the appropriate service to minimise the risk of this happening again. 	

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

Event	Specific action taken
A GP on a home visit was subjected to verbal, racial hostility from members of the public.	The practice discussed the incident and reviewed processes for safety when lone working. As a result, staff now utilised a personal safety app on their phones. The app allows staff to quickly and safely alert the practice and enable them to take action to protect the staff member.
A combination of prescribed medicines contributed to the death of a patient.	The practice undertook an audit to establish a register of patients taking a combination of certain medicines that may cause serious complications. Those patients identified were reviewed by a GP and where necessary their medicines were changed. A follow up audit was planned for 2020.

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

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	73.3%	N/A	80% Target	Below 80% target

64). (31/03/2019 to 30/06/2019) (Public Health England)

Any additional evidence or comments

Previously (January 2019) we told the practice they could continue to improve cervical smear attendance as figures by Public Health England (PHE) showed they were below the expected target of 80%.

The practice had appropriate processes in place to encourage women to attend including appointment availability at differing times with a female sample taker. Current PHE data (June 2019) indicated the practice had not progressed in meeting the target.

We reviewed the practice data on the day of the inspection which reviews attendance in relation to annual expectations. The unverified data showed the percentage of women who had attended cervical screening within the appropriate timeframe:

- 1,598 women aged between 25 and 49 had attended for screening. (80%)
- 917 women aged between 50 and 64 had attended for screening. (85%)

Carers	Narrative
Percentage and number of carers identified.	526 patients had been identified since our previous inspection which equates to 4% of the practice population. Previously, the identification rate was 1.6% of the practice population.
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> • A trained carers champion was in place. • A carers pack for newly identified carers containing information about local support groups and services was available. • Additional carers pack dependent on need or circumstances were available.

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.