

Care Quality Commission

Inspection Evidence Table

Hounsfield Surgery (1-879698093)

Inspection date: 22 January 2020

Date of data download: 21 January 2020

We carried out an announced focussed inspection of Hounsfield Surgery on 22 January 2020. This inspection was undertaken to follow up on breaches of regulations which had been identified at our previous inspection in October 2019 in relation to safe care and treatment and good governance.

Safe

Safety systems and processes

| Safeguarding | Y/N/Partial |
|---|-------------|
| 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 and procedures were monitored, reviewed and updated. | Y |
| Partners and staff were trained to appropriate levels for their role. | Y |
| Staff who acted as chaperones were trained for their role. | Y |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none">The inspection in October 2019 found that some staff could not easily access policies and procedures relating to safeguarding and safeguarding policies did not contain the correct details for contacting the local authority safeguarding team. At the follow up inspection in January 2020 we found that safeguarding policies and procedures were now easily accessible to staff and contained the correct details for contacting the local authority safeguarding team. Safeguarding processes had also been discussed at a recent team meeting.The inspection in October 2019 found that training records were not available on the day of inspection to demonstrate that all staff had completed safeguarding training to the appropriate level. At the follow up inspection we found that all staff had now completed training to the appropriate level.The inspection in October 2019 found that training records were not available on the day of inspection to demonstrate that all relevant staff had completed chaperone training. At the follow up inspection we found that all relevant staff had now completed training to the appropriate level. | |

| Recruitment systems | Y/N/Partial |
|--|-------------|
| Recruitment checks were carried out in accordance with regulations (including for agency | Y |

| | |
|---|---|
| staff and locums). | |
| 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>The inspection in October 2019 found that recruitment files contained gaps in documentation to demonstrate that all appropriate pre-employment checks had taken place. No system was in place for ensuring that staff had maintained all recommended vaccinations and the practice relied upon clinical staff to tell them when they had renewed their registration, the practice did not have a system for checking that clinical staff remained registered. At the follow up inspection in January 2020 we found that appropriate pre-employment checks had been completed for a recently recruited staff member, a record of staff vaccinations was now in place and a system was now in place for checking clinical staff remained registered with their professional body.</p> | |

| Safety systems and records | Y/N/Partial |
|---|-------------|
| There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. | Y |
| There was a log of fire drills. Date of last drill: | N |
| <p>Explanation of any answers and additional evidence:</p> <p>The inspection in October 2019 found that no risk assessments had been completed for the storage of liquid nitrogen or oxygen and there was no record of fire drills available on the day of inspection. At the follow up inspection in January 2020 we found that these risk assessments were now in place. A fire drill was scheduled to take place shortly. Fire procedures had been discussed at a recent team meeting.</p> | |

Infection prevention and control

| | Y/N/Partial |
|--|-------------|
| <p>Infection prevention and control audits were carried out.</p> <p>Date of last infection prevention and control audit: 13 January 2020</p> | Y |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The inspection in October 2019 found that Infection control audits had been completed by the CCG, however, the practice had not completed internal audits or other documentation to evidence cleaning standards. This documentation included cleaning schedules and equipment decontamination records. At the follow up inspection in January 2020 we found that the practice had completed an internal infection control audit, had put cleaning schedules in place and equipment decontamination records were being completed. The inspection in October 2019 found that the premises were clean and well maintained, however, we found that curtains in clinical rooms had not been replaced within recommended timeframes. At the follow up inspection we found that the premises remained clean and well maintained and the curtains had been replaced in the clinical rooms and a system was now in place to ensure curtains were replaced at appropriate intervals. | |

Information 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 |
| The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols. | Y |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The inspection in October 2019 found that care records were managed securely but lacked detail at times. Regular clinicians had a good knowledge of their patients, but care records did not always provide sufficient detail for temporary staff being used by the practice. At the follow up inspection in January 2020 we found that care records now contained an appropriate level of detail. The inspection in October 2019 found that the practice shared information with other service providers, however, practice staff did not always check that patients were receiving regular blood tests from other service providers as required before repeat prescribing high-risk medicines. At the follow up inspection we found that a system was now in place and practice staff were now checking that patients had received regular blood tests as required before repeat prescribing high-risk medicines. | |

Appropriate and safe use of medicines

| 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 |
| 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 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> <ul style="list-style-type: none"> The inspection in October 2019 found that found the dispensary located at the practice did not have its access restricted to authorised persons only. At the follow up inspection in January 2020 we found that appropriate security arrangements were now in place. The inspection in October 2019 found that record was not being kept of where blank prescriptions were being distributed to within the practice. Prescription stationery was also left unattended in unlocked clinical rooms at times. At the follow up inspection we found that appropriate security | |

| Medicines management | Y/N/Partial |
|---|-------------|
| <p>arrangements were now in place.</p> <ul style="list-style-type: none"> The inspection in October 2019 found that there were effective processes in place for monitoring patients' health in relation to some high-risk medicines including lithium and warfarin. However, two patients receiving methotrexate had not received recent blood tests as required. At the follow up inspection we found that processes had been improved and the five patients we reviewed who were receiving methotrexate had received blood tests as appropriate. The inspection in October 2019 found that adrenaline was available in all appropriate areas, however, no other emergency medicines were easily accessible in the event of a medical emergency. There was no Glucagon, Glucagel or diclofenac in the practice and no risk assessment had been carried out to assess the risk of not stocking these medicines for use in the event of a medical emergency. At the follow up inspection we found that all appropriate emergency medicines were now easily accessible. The inspection in October 2019 found that no documentary evidence was available to show that the medical emergency equipment was regularly checked to ensure it was fit for use. Some oxygen masks were out of date. At the follow up inspection we found that emergency equipment was checked weekly and no oxygen masks were out of date. The inspection in October 2019 found that the procedure for monitoring temperatures of the vaccine refrigerator in the dispensary was not working effectively. At the follow up inspection we found that the procedure was now working effectively. | |

| Dispensary services (where the practice provided a dispensary service) | Y/N/Partial |
|---|-------------|
| 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 |
| <p>Explanation of any answers and other comments on dispensary services:</p> <ul style="list-style-type: none"> The inspection in October 2019 found that the procedure for monitoring temperatures of the vaccine refrigerator in the dispensary was not working effectively. At the follow up inspection in January 2020 we found that the procedure was now working effectively. The inspection in October 2019 found that some medicines were added to medicines compliance aids cut from a foil blister pack, retained in the foil packing. Guidance recommends that medicines should not be repackaged within medicine compliance aids in their original strip or blister packaging, because of reports of patients swallowing the medicine and its packaging, resulting in patient harm. At the follow up inspection we found that this practice was no longer taking place. | |

Track record on safety and lessons learned and improvements made

| Significant events | Y/N/Partial |
|---|-------------|
| There was evidence of learning and dissemination of information. | Y |
| Explanation of any answers and additional evidence: The inspection in October 2019 found that dispensary staff were aware of learning from incidents but there was no evidence of wider learning across the practice. Significant events and near misses had only been reported by the dispensary. No other incident or near miss reporting had taken place. Formal team meetings did not take place regularly and there was no evidence of learning from significant events at these meetings. At the follow up inspection in January 2020 we found that significant events were now also being reported by non-dispensary staff and we saw that documentation was detailed and contained a clear analysis of the event, learning and actions taken to minimise the risk of re-occurrence. Team meeting minutes recorded where events had been discussed and learning shared with staff. The significant event policy had also been reviewed since the last inspection. | |

| 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: The inspection in October 2019 found that the system for recording and acting on safety alerts was not effective. Not all patient safety alerts were being received and acted on appropriately. It also found that the system for recording and acting on safety alerts was unclear. At the follow up inspection in January 2020 we found that a clear systems was now in place for recording and acting on safety alerts and we saw examples of action taken following alerts received since the last inspection. | |

Effective

Effective needs assessment, care and treatment

| | Y/N/Partial |
|--|-------------|
| Patients' treatment was regularly reviewed and updated. | Y |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">At the inspection in October 2019 we checked the records of six patients with diabetes. Three of the patients had blood sugar results outside of their recommended range and a change in their medicines had been made. None of the three patients had received a review or been booked in for a review. Patients with blood sugar results outside of their recommended range should receive a review within three months of a change in their medicines to assess the effectiveness of any changes. At the follow up inspection in January 2020 we found that patients with diabetes had been reviewed where changes in medicines had been made.At the inspection in October 2019 we found that clinicians could explain the advice they would give to patients on when they needed to seek further help, however, clinical records did not contain details of this advice. At the follow up inspection we found that clinical records now contained details of this advice. | |

Monitoring care and treatment

| | 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

The inspection in October 2019 found that the practice completed audits which identified shortcomings, but actions were not always identified to address these shortcomings and timescales for any identified actions were not always stated. At the follow up inspection in January 2020 we found that the practice had completed audits and identified actions and timescales for actions where appropriate.

Effective staffing

| | Y/N/Partial |
|--|-------------|
| Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme. | Y |
| 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 |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Y |

Explanation of any answers and additional evidence:

- The inspection in October 2019 found that evidence of some training completed by some staff was seen but comprehensive training records were not available on the day of inspection to demonstrate that all staff had received had received all relevant training. At the follow up inspection in January 2020 we found that uptake of training had improved and comprehensive training records were now in place.
- The inspection in October 2019 found that some staff had received a form of appraisal but not all staff were receiving regular appraisal. At the follow up inspection we found that the majority of staff had received an appraisal and all other staff had a date scheduled for their appraisal to take place.
- The inspection in October 2019 found that the poor staff uptake of training courses made available by the provider had not been addressed. At the follow up inspection we found that uptake of training had improved.

Responsive

Listening and learning from concerns and complaints

| | Y/N/Partial |
|---|-------------|
| Information about how to complain was readily available. | Y |
| Explanation of any answers and additional evidence: The inspection in October 2019 found that complaints information was not comprehensive and did not consistently refer to the patients' rights to contact NHS England and the Parliamentary and Health Service Ombudsman. At the follow up inspection in January 2020 we found that the complaints procedure and policy had been reviewed and now contained comprehensive, accurate information for staff and patients. | |

Well-led

Culture

| | Y/N/Partial |
|---|-------------|
| 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 |
| Explanation of any answers and additional evidence: The inspection in October 2019 found that no policies or procedures were in place to support the duty of candour and training records were not available on the day of inspection to demonstrate that all relevant staff had completed duty of candour training. At the follow up inspection in January 2020 we found that a duty of candour policy was in place and had been discussed at a team meeting. Two lead staff had completed 'Being open' training and were sharing this learning with staff. | |

Governance arrangements

| | Y/N/Partial |
|---|-------------|
| Staff were clear about their roles and responsibilities. | Y |
| Explanation of any answers and additional evidence: The inspection in October 2019 found that policies and procedures were not easily accessible for all staff. At the follow up inspection in January 2020 we found that the number of policies and procedures had been reduced and were now easily accessible to staff. Team meeting minutes recorded where this had been discussed with staff to raise awareness. | |

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.