

Care Quality Commission

Inspection Evidence Table

Bulbanks Medical Centre (1-5719000558)

Inspection date: 22 January 2020

Date of data download: 20 January 2020

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

Well-led

Rating: Unrated

Governance arrangements

Governance arrangements had improved as there was an up to date policy framework covering those areas of activity we checked, and leaders had worked to implement other systems. We found the overall governance arrangements consistently ensured patient safety.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y ¹
Explanation of any answers and additional evidence:	
September 2019 inspection At our last inspection in September 2019 Governance arrangements were in place at the practice, but in some instances outcomes of meetings and policies and procedures were not documented. The practice had explained that the Practice Manager was new to their role and had been in post since April 2019 and was still sorting through the previous Practice Manager's files. The Practice Manager told us they had started to review and update all practice policies in April when they took over the role.	
This inspection 1 – At this inspection the practice had started using a practice management resource tool to update the practice's policies and procedures. We reviewed several of the practice's policies including policies related to management of Legionella bacteria, staff training and appraisals protocols, safety alert policy and health and safety policy. All policies contained relevant information including details of those in lead roles. The policies we looked at had future review dates. The Legionella policy we reviewed had been updated in November 2019. At this inspection the overarching governance framework ensured that processes were happening in line with policy or legal requirements for example, • Policies were reviewed to indicate essential training required for staff to perform their role. At the last inspection we found that there was no system in place to monitor staff training. At this inspection we saw that the provider had oversight of staff training and could easily evidence the	

training undertaken by staff. The provider showed us an online training tool used to schedule and monitor staff training. The provider was sent an alert when staff training was due.

- Staff files we reviewed showed that all staff were up to date with essential training. We reviewed the file of the member of staff who had not been up to date with their essential training at the last inspection. At this inspection we saw they had completed all essential training online.
- There was an effective system in place to ensure appraisals were being monitored. Staff files we reviewed showed all staff had received an appraisal or had an appraisal date scheduled.
- At our last inspection outcomes of meetings were not always minuted. Practice staff told us at this inspection that non-clinical staff meetings were held every two months and we reviewed minutes of the practice meeting held in October 2019. We asked to look at the minutes from the practice meeting for December 2019. The Practice Manager told us there was an end of year meeting scheduled for 17th December however, this was cancelled due to the clinical system going live between 13-16 December. Due to staff end of year annual leave we were told the next meeting was arranged for 25th February 2020.

Managing risks, issues and performance

Risks associated with staff training and development and the premises had been addressed since our last inspection and a programme of risk assessments had been initiated.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y ¹
Explanation of any answers and additional evidence: September 2019 inspection At our last inspection Leaders had not ensured they had oversight of systems and processes so that risks were managed effectively in the practice. For example, there were no procedures to monitor Legionella and no legionella risk assessment had been carried out. At this inspection the practice had implemented effective processes for managing risks. For example, the practice showed us the risk assessment for Legionella completed in November 2019. The risk assessment had a column to record any identified risks. This inspection 1 – At this inspection we saw a copy of the Legionella test certificate. The test was carried out by an external testing company and no legionella bacteria were isolated in the sample analysed. Since our last inspection the provider had implemented monthly checks to monitor the risk of legionella. Staff showed us their log of water temperature checks of the water system. We saw temperature readings were within safe levels.	

Appropriate and accurate information

The practice acted on appropriate and accurate information.

	Y/N/Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	Y ¹
There were effective arrangements for identifying, managing and mitigating risks.	Y ²
Explanation of any answers and additional evidence: September 2019 inspection At our last inspection, individual care records were not always written and managed securely and in line with current guidance and relevant legislation. For example, the provider did not have effective systems in place to ensure that all patients with mental health conditions had appropriate reviews. There was no record that a copy of the review was saved in the clinical record so that it was available for all who may be involved in the service user's care. At our last inspection, leaders had not ensured they had oversight of systems and processes so that risks were managed effectively in the practice. The arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not operated effectively, in particular in relation to Legionella control. This inspection 1 – At this inspection the process of reviews had improved. The practice had migrated to the EMIS patient record system in December 2019. We asked to look at a sample of care plans. At this inspection the practice had 22 patients on their mental health register. We looked at all 22 patients with the reviewing clinician. The reviewing clinician said they had reviewed 14 of these patients since our last inspection and we saw all had a care plan in place. We looked at the records of the three service users with dementia which we looked at during our last inspection. We saw a copy of the care plan in each of these patients' records and the reviewing clinician had completed the record in sufficient detail to ensure the care plans remained person-centred and appropriate for the service user's needs. There were 17 services users registered as living with dementia. All the review records we saw were adequate; we saw the provider had completed 13 dementia care reviews since our last inspection. We looked at nine records out of 14 patients registered with a mental health condition. All nine patients were reviewed appropriately, and all had been reviewed since our last inspection. The provider told us they had started using a template in the new patient record system to record information about the review. We looked at 10 records out of the 12 adult patients on the Learning Disability register. All had been reviewed by the Advanced Nurse Practitioner. Five of those patients had received a review since our last inspection and records we looked at showed patients were reviewed appropriately, and care plans were accurate and complete. The nurse also used the template in the new patient record system to record information about the reviews. 2 – At this inspection, risks associated with the premises, for example, control of Legionella had either been addressed or were in the process of being addressed. Recruitment, training and appraisal processes had improved and the practice were in the process of setting up systems to oversee staff training.	

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 ¹
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: 1– At our last inspection, the provider had not established an effective system of staff appraisals where the learning needs of staff were identified. At this inspection, the provider told us they had reviewed the appraisal process and had implemented a new system to manage the schedule of appraisals. The provider had created an appraisal management folder for the GP partner to monitor staff appraisals. The provider told us they took responsibility to review the scheduled appraisals every month. Staff files we reviewed showed all staff had received an appraisal or had an appraisal date scheduled. We spoke to the members of staff who had been appraised who informed us that the appraisal was a two-way discussion in which they were able to provide input and ask for additional training, development and support. At our last inspection the Practice Manager was not able to find a copy of their own appraisal record. At this inspection we saw a copy of their six-month review which had been signed off and dated. The provider was in the process of migrating to EMIS patient record system. The practice was receiving support from the CCG IT team and had a programme of training days for staff in place. The provider had joined as a member of the North Bexley PCN and were in the process of developing new service arrangements which included plans to engage a pharmacist to work at the practice to support medicines management and a social prescriber to support patient care. The provider told us their planned merger with a larger established local practice had been approved.	

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
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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.