Care Quality Commission

Inspection Evidence Table

Weston Lane Surgery (1-568347680)

Inspection date: 14 January 2020

Date of data download: 08 January 2020

Overall rating: Good

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

Safe Rating: Good

At the previous inspection on 25 February 2019, safe was rated as requires improvement because shortfalls were found around the process for managing medicines particularly in regards to cold chain storage. There were also areas for improvement around fire safety across the sites but was not in breach of regulation for this area. At this inspection we found the practice had made improvements to these areas and maintained safe systems resulting in safe now being rated as good.

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.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes

Safeguarding	Y/N/Partial
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.	Yes

Explanation of any answers and additional evidence:

The practice had a process in place whereby clinicians would undertake chaperoning in the first instance. If no clinician was available then chaperoning would be undertaken by a pool of trained non-clinical staff. All staff trained to chaperone had a DBS in place.

All staff had received training in safeguarding children and adults. The practice told us that they had set themselves a target of having all clinical staff receive face to face level three training by December 2019. This target had not been achieved due to difficulties in booking all staff onto the training course in this timescale. The practice told us they had contacted the organisers who were aware of the practice's need and that additional sessions were now being organised to accommodate staff. In the meantime, staff had been completing the e-learning safeguarding refresher training to ensure they maintained up to date with the latest safeguarding processes.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes

Explanation of any answers and additional evidence:

Since our last inspection in February 2019, the provider (Living Well Partnership) had changed their processes for oversight and monitoring of HR and recruitment. HR and recruitment is now undertaken centrally at provider level and contains information about all staff who work across all sites under the banner of The Living Well Partnership (this includes the registered location Weston Lane Surgery and associated branch sites). Previously HR management was completed using a combination of external advice and in-house support. The provider (Living well Partnership) has now recruited an in-house CIPD certified team of a HR Manager and HR and Payroll Coordinator to review, revise and manage existing processes. Recruitment was now stored on an electronic platform. This platform was still being finalised at the time of our inspection and required a large transfer of existing data onto it. During the transition period there were alternative electronic storage processes in place to ensure recruitment checks were undertaken and accurately recorded. There was a colour coded system in place to identify for each staff what documents had been completed and a robust system for monitoring. We saw evidence via the colour coded matrix that all relevant documents had been collected including immunisation status of staff.

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: Weston Lane: 26 February 2019	Yes
There was a record of equipment calibration. Date of last calibration: Weston Lane: October 2019.	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: Weston Lane 20 November 2019	Yes
There was a log of fire drills. Date of last drill: Weston Lane 8 October 2019	Yes
There was a record of fire alarm checks. Date of last check: Weston 27 January 2020 (tests are undertaken weekly)	Yes
There was a record of fire training for staff. Date of last training: Dates varied for each staff.	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: July 2019	Yes
Actions from fire risk assessment were identified and completed.	Yes

Explanation of any answers and additional evidence:

PAT testing was undertaken every other year. We saw a copy of the PAT testing certificate for Weston Lane surgery which stated the next test date of 2020. We were told this needed to be amended to 2021 as their policy was for testing to be undertaken every other year.

Calibration and PAT testing of branch sites were currently undertaken at different times due to different contracts for each site. The facilities lead was in the process of streamlining contracts into one single contract. We saw copies of the certificates for each site.

At our previous inspection in February 2019, we identified that there were different systems and processes for oversight of fire safety at each of the branch sites. Since that inspection there has been a change to the oversight of the processes. Each branch site now had a standardised fire safety pack which contained all relevant documents including the policy, contact details and records of all relevant checks and tests which could be handed over to the fire department when required. Although checks were site specific the main bulk of the information was standardised and in the same document wallets for all staff to identify.

All staff had undertaken fire safety training at different times but all in line with their expected timescales for routine updates. We were told that this training was delivered through an electronic learning package and was included as part of the induction process as well as when a refresher update is required.

All reception staff had been trained as fire marshals. The leadership team at provider level made this decision as this means that staff can work across sites and that training all staff ensured there was always a fire marshal working at each site. The fire marshal for the day is the staff member who is allocated to working on front desk. There was a standardised fire procedure behind the desk that was the same for each site (with the exception of the site address).

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: Rolling process.	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Rolling process	Yes

Explanation of any answers and additional evidence:

Since our previous inspection in 2019, the practice had introduced a piece of software to help with oversight and monitoring of all things to do with maintenance and risk assessments across all sites. The process allowed for constant monitoring and logging of issues regarding maintenance and these were then categorised on an overarching action plan. The new system was an improvement from their existing system as this software package allowed for tasks to be allocated and monitored in regards to progress of specific maintenance issues. There was also a system whereby documents relating to the issue could be attached for ease of reviewing and continuity rather than having them stored separately or logging as a separate issue. The practice had adopted a process whereby risk assessments were reviewed at monthly meetings and actions updated accordingly. The facilities manager had overarching oversight of the processes, however, under the new system other staff, including the business manager, were able to log on and monitor actions. We saw examples of when information was logged on the system and actions that had been documented and undertaken. For example, a need to update internal lighting was in progress at the time of our inspection. Under the practices red, amber, green risk rating this had been rated as a low risk issue.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: February 2019	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes

Explanation of any answers and additional evidence:

Since the previous inspection the practice had further improved processes for monitoring infection control. This included having a dedicated infection control lead and identifying additional staff as infection control champions.

staff had received additional training in infection control with a purpose to promote good infection control procedures at each site. We saw examples of the types of infection control monitoring that was undertaken including revised room cleaning schedules which were standardised across Weston lane and each branch site.

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.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
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.	Yes

There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes

Explanation of any answers and additional evidence:

Since our previous inspection the practice had purchased a new piece of software for oversight of HR processes. This included an ability to track absences of staff and highlight any potential risk issues or performance issues. Since recruiting staff to manage the HR processes, the practice felt they had a stronger understanding of staffing need and demand. We were told that there had been a recruitment drive to fill vacancies and staff worked across all sites in order to fill resources where required. We were told that there had been a reduction in locum use across the provider and that this was attributed to a shift in looking at resources internally, working across organisation, recruiting to vacant roles and GPs picking up additional sessions to cover deficits.

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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
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.	Yes

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)	0.76	0.77	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)	10.1%	10.6%	8.5%	No statistical variation
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)	6.47	6.51	5.60	Tending towards variation (negative)
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)	2.94	2.24	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.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
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.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes

Medicines management	Y/N/Partial
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.	Yes
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.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
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.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes

Explanation of any answers and additional evidence:

The practice during the Annual regulatory review process told us that there was an antibiotic stewardship guardian attached to the practice to support the ongoing reviewing of prescribing data.

The practice told us that there was a process in place for repeat prescription requests. The process did not routinely alert for a review by a clinician to authorise any issues beyond the review date or authorised number of repeats. We were told that the current process was for a clinician to review opportunistically when a patient presented for an appointment or request for prescription. The practice told us that they had recently employed a pharmacist would be taking on the lead role in looking at patients on routine medicines to triage and determine whether a face to face visit was required prior to issuing another prescription or whether or whether the prescription could be reauthorised.

The practice told us they completed a quarterly Royal College of General Practitioners safe medicines prescribing audit.

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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	94
Number of events that required action:	94
Explanation of any answers and additional evidence: Significant events were captured and reviewed at an organisational level. There had been 94 recorded significant events since January 2019. This included events from the provider's other registered location and all branch sites. Data was captured this way in order to share learning at a wider level.	

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

Event	Specific action taken
Patient data confidentiality breach.	A member of staff had accessed a patient record without a need to. There was a safeguarding concern attached to this patient's records which impacted the patient's circumstances. The practice was alerted to the issue by another member of staff who was concerned about the data confidentiality breach. The practice followed their process for investigating the event. Following the investigation, the staff member was dismissed, patient contacted and an additional flag added onto the records of the family that data security was required. This example was then used to remind staff on what types of information governance and data breaches could be.
Missed 2 week wait referral.	No EMIS task had been sent to the secretary for a two week wait referral so the team was not notified and processes not completed. This was actioned immediately when the issue was identified. As a result of this, the practice had added an F12 protocol on the computer which allows quicker and easier access for GPs to complete the process. The locum pack was also updated to reflect the changes. Weekly audits were now routinely completed and as of 10 January there were no missed referrals.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes

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.