Care Quality Commission

Inspection Evidence Table

Dr RM Roope and Partners (1-553995204)

Inspection date: 12 February 2020

Date of data download: 29 January 2020

Overall rating: Good

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

Safe Rating: Good

The rating has improved from Requires Improvement to Good because:

- Legionella and fire risk assessments were up to date and appropriate actions had been undertaken.
- Other arrangements to ensure safe services had been maintained.

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

Safeguarding	Y/N/Partial
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: There was a safeguarding lead in place at the time of the inspection, who had received appropriate training. All GPs and nurses had received Safeguarding level 3 (children and adults) training. There were appropriate, up to date, safeguarding policies in place. We reviewed minutes of safeguarding meetings held which included local health visitors. This demonstrated the practice was working with community representatives to keep children and vulnerable adults safe.	

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.	Partial
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence: We checked recruitment files in relation to five members of staff and found these were compliant with regulations. The practice had not maintained staff vaccination records in line with Public Health England guidance. The practice could not demonstrate they were assured that, all staff who had direct contact with patients, were up to date with routine immunisations such as tetanus, polio and rubella. The practice had maintained records in relation to hepatitis B and influenza vaccinations for all 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: 9 March 2019	Y
There was a record of equipment calibration. Date of last calibration: 29 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: 10 February 2020	Y
There was a log of fire drills. Date of last drill: December 2019	Y
There was a record of fire alarm checks. Date of last check: 6 February 2020	Y
There was a record of fire training for staff. Date of last training: 11 February 2020	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 1 May 2019	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: At our previous inspection on 8 January 2019, we found that the practice did not have a log demonstrating that fire drills had taken place, fire alarm checks had not taken place on a regular basis and there was no current fire risk assessment in place. At this inspection we found records confirmed that regular fire alarm checks had taken place. Records also confirmed that several fire drills had taken place since the last inspection. An appropriate fire risk assessment was in place and all actions had been completed.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: February 2020	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 25 April 2019	Y
Explanation of any answers and additional evidence: At our previous inspection on 8 January 2019 we found that actions from the legionella risk assessment had not been addressed. This included monthly water temperature checking which was in line with the practice's own legionella policy. We also found that actions from a Health and Safety risk assessment	

had not been completed.

At this inspection, we found that a legionella risk assessment had been undertaken on 21 November 2019. As a result, the practice had implemented a system of water temperature checking to ensure water temperatures for the practice remained within low risk parameters. The practice started this on 27 January 2020.

In addition, a water sample had been tested for the presence of legionella on 27 November 2019 and none had been detected.

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:17 December 2019	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:

There was an up to date infection control policy in place. A representative from the practice attended infection control link meetings within the wider community.

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:

The practice held staff education evenings which followed a Local Medical Committee (LMC) education programme. Sepsis had been covered as part of the programme. We saw evidence that the practice used recognised scoring systems to identify adults and children at risk of sepsis.

The practice had a system in place to manage unexpected staff absences. The reception manager was able to cover administrative and reception roles. GPs covered absence by taking on extra sessions and locums were used if necessary. Nurses rescheduled appointments based on priority.

There was an identified duty doctor each day. Patients who required same day care were referred to the same day access service at a local community hospital. This was a service provided jointly by the practice with local partners.

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:

The practice used a patient record system in common with other local practices, who jointly provided the same day access service at a local hospital. This allowed GPs providing same day care to patients to access patient records regardless of which practice they were registered with.

The practice had recently instigated a new system where the designated duty doctor for the day did not undertake any routine consultations with patients. This ensured the duty doctor was available to deal with routine administrative work such as reviewing and actioning test results, repeat prescribing, patient requests for acute prescriptions, responding to actions in patient discharge letters and dealing with any queries or emergencies. We were told this new system worked more effectively for both GPs and patients and ensured requests were dealt with in a more timely manner rather than at the end of a clinic.

The practice had signed up to the NHS Summary Care Record (SCR). The NHS Summary Care Record (SCR) is an electronic summary of key clinical information (including medicines, allergies and adverse reactions) about a patient, sourced from the GP record. It is used by authorised healthcare professionals, with the patient's consent, to support their care and treatment in other parts of the NHS. This allows other healthcare professionals to have access to key medical history information about patients.

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)	0.36	0.76	0.87	Significant Variation (positive)
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)	10.0%	9.1%	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)	7.03	5.58	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)	1.82	2.64	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.	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.	NA
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

Explanation of any answers and additional evidence:
The practice acknowledged higher than average prescribing for uncomplicated urinary tract infection. The practice felt this was due to their care of patients at a local nursing home where patients were frequently diagnosed with urinary tract infections. These patients met the criteria for seven days prescribing rather than the average of three days.

We reviewed prescribing audits which demonstrated that the practice was working with the Clinical Commissioning Group (CCG) to meet their prescribing guidelines and optimise the most effective use of medicines. Outcomes demonstrated that the practice needed to continue improving in this area.

We found the practice had taken appropriate actions to destroy vaccines which had not been kept at an appropriate temperature due to a fridge failure over a weekend. As a result, the practice had changed its practice and monitored fridge temperatures via a data logger. A review of data logger outputs demonstrated that fridge temperatures remained within safe parameters.

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.	Partial
Number of events recorded in last 12 months:	12
Number of events that required action:	12
Explanation of any answers and additional evidence: We reviewed minutes of significant event meetings which had taken place in June and October 2019. The meetings had been attended by GPs. The practice told us that the next meeting planned for 28 February 2020 included GPs and representatives from all staffing groups to ensure greater clarity of dissemination of learning to all relevant staff in a timely way.	

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

Event	Specific action taken
Patient referral was made in wrong name as two patients had the same name.	The practice updated standard operating procedures (SOPs) for all reception procedures and this included checking the patient's date of birth before a referral was made.
Incorrect hormone replacement therapy (HRT) was prescribed.	An HRT educational session had been planned at the practice
The vaccine fridge failed over a weekend.	The practice could not be sure what the fridge temperatures were over the weekend or how long the vaccines had been at an incongruent temperature and therefore the entire vaccines stock had to be destroyed for safety reasons. The practice installed a data logger to ensure they were able to monitor fridge temperatures when the practice was closed.

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 reviewed evidence that safety alerts had been dealt appropriately including relevant searches.	

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.