

# Care Quality Commission

## Inspection Evidence Table

### St Mary's Island Surgery (1-4867909740)

Inspection date: 10 July 2020

Date of data download: 08 July 2020

## Overall rating: No rating given

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

## Safe

## Rating: No rating given

### Safety systems and processes

**The practice did not have effective 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
There were systems to identify vulnerable patients on record.	Y
Staff who acted as chaperones were trained for their role.	Y
Explanation of any answers and additional evidence: The practice had an appointed clinical lead and a deputy for safeguarding. We sampled three safeguarding records and found that there was inconsistent identification, recording and actioning of risks. For example: one family had all family members flagged as at risk with the exception of the youngest child. Another family had only one family member flagged as at risk and all other members had deregistered. One child who had an active safeguarding flag on their patient record had not been seen by the practice for a number of years. There was no narrative entry on the patient record to evidence the child was safe. All relevant staff had received chaperone training. However this was completed on 6 July 2020 over a month later than stipulated on the warning notice previously issued by CQC.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
Explanation of any answers and additional evidence:	

References are required to be obtained prior to the appointment of staff. In the January 2020 inspection of the practice we had found staff had been appointed without references being obtained. Consequently, risk assessments had been conducted retrospectively. These were required to be completed by 13 May 2020. We found three of the four staff had their assessments completed over a month later on 26 June 2020.

Where a member of staff had a conviction recorded on their DBS certificate we found their suitability for their role had not been appropriately assessed. The practice had not sought information to confirm the nature of the conviction, their report failed to state if they were to appoint or decline the applicant the position and the document had not been endorsed by the Head of Human Resources as required on the provider's form.

The practice had previously been unable to demonstrate that all clinical staff had been appropriately immunised prior to undertaking clinical duties. During this inspection we found appropriate checks had been conducted.

Safety systems and records	Y/N/Partial
There was a fire procedure.	N
There was a log of fire drills. Date of last drill: 19 February 2020	Y
There was a record of fire alarm checks. Date of last check: 19 February 2020	Y
Explanation of any answers and additional evidence: Records showed fire extinguishers had been checked on 12 February 2020. There were fire evacuation procedures in place at the branch surgeries but they were found to be ineffective. For example, a fire evacuation drill was conducted on 19 February 2020 at Pentagon branch surgery. No staff present within the building were aware of the fire drill sounding until alerted by staff in a neighbouring premises. The report on the rehearsal failed to identify learning or how the issue had been resolved to mitigate a reoccurrence.	

Health and safety	Partial
The practice was required to conduct legionella assessments at each of their surgeries. Due to COVID 19 many of the branch surgeries were closed and their assessments delayed. However, Pentagon Surgery had had an assessment conducted on 6 February 2020 and signed off as completed on 1 April 2020. The next review date had been set for 1 July 2020.	
The practice submitted evidence to show the front door closure mechanism for St Mary's Island Surgery had been repaired. The door was not operational at the time of our inspection due to restrictions on patient access because of COVID 19.	
A project plan was in place for the redecoration of the surgeries.	

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were not met.**

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Infection prevention and control audits were carried out.	N
Date of last infection prevention and control audit: Medway NHS Healthcare Centre	15 January 2020
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: The practice submitted a blank infection prevention control audit for St Mary's Surgery. The practice was required to assess and ensure the safe management of clinical waste at Twydal Branch Surgery by 13 May 2020. Email correspondence dated 20 January 2020 showed the practice had sought assurance from their clinical waste disposal specialists that such waste was safe on the condition it was kept secure pending collection. The risk assessment was dated 22 June 2020.	

## Risks to patients

**There were ineffective 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.	N
Explanation of any answers and additional evidence: We reviewed a selection of staff rotas and found overall clinical cover was lower than at our previous inspection in January 2020. For example, we found, a GP who was absent long term since 2019 was still shown on staff rotas. We reviewed rotas for five separate weeks from 23 March 2020 to the week commencing 6 July 2020. GP cover ranged between 4 to 1.25 full time equivalent for a patient population of 27,640; insufficient to meet the needs of patients. With four clinical sessions on each of the sample weeks provided remotely.	

## Information to deliver safe care and treatment

**Staff did not have 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.	N
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	N
There was a documented approach to the management of test results and this was managed in a timely manner.	N
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed the management of five patients with Chronic Obstructive Pulmonary Disease (COPD). We found the patient records to be incomplete, not detailing the number of hospital admissions by the patient and/or the monitoring of new medication such as the issuing of an inhaler. The practice had failed to follow the GOLD international COPD guidelines in the management for all the five patients.</p> <p>We reviewed all clinical meeting minutes since February 2020. We were provided with clinical meeting minutes dated 2 June 2020 and no others for the five month period. Within these were details of significant incidents such as the identification of 500 patient related documents unactioned dating back to October 2019. There was no details of who and how these were addressed and what measures had been put into place to ensure this did not reoccur.</p> <p>We also reviewed the meeting minutes from the Primary Care Safety Huddles of 8 July 2020. These were a recent introduction and had only been held on the one occasion. The agenda, discussion, actions and timescales required for the completion of actions were not clear.</p>	

## Appropriate and safe use of medicines

### The practice did not have effective systems in place for the appropriate and safe use of medicines, including medicines optimisation

Medicines management	Y/N/Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	N
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	N
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.	N
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.	N
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	N
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.	Partial
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> <p>We asked the practice to provide evidence of all current Patient Group Directions (PGDs). Patient Group Directions (PGDs) provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber). We reviewed two PGDs for the Sunlight Centre, a branch surgery of St. Mary's Island Surgery. We found both were out of date, expiring in February and March 2020. However, the surgery was not open at the time of our inspection due to COVID 19.</p> <p>We reviewed the practice's management of nine patients receiving warfarin medication. Warfarin is used to prevent blood clots from forming or growing larger in your blood and blood vessels. It is prescribed for people with certain types of irregular heartbeat, people with prosthetic (replacement or mechanical) heart valves, and people who have suffered a heart attack. We checked nine patient records, five were found to be acceptable. The remaining four patients' records showed a lack of follow up dates for medication to be reviewed, or a reduction or stopping of their medication independently of discussion/consultation with the patient and contrary to the practice's prescribing policy.</p>	

Medicines management	Y/N/Partial
<p>We looked at the records of 10 patients who were prescribed methotrexate. We found one patient was not receiving care in line with the current guidance requiring blood tests every two to three months.</p> <p>We looked at the records of five patients who were prescribed lithium and found all five patients had not received appropriate care. For example, we found patients had not received follow up blood tests, medication reviews and/or a reduction in the medication when failing to engage with the service in the safe monitoring of their care. This was contrary to the practice medicine management policy.</p> <p>Checks were conducted of doctors' bags but these were not site specific, examples of medicines in date were shown. No evidence was provided to demonstrate spare automated external defibrillation pads were available at Sunlight Centre. However, the branch surgery was closed at the time of our inspection due to COVID 19.</p> <p>The practice's clinical audit conducted on 24 October 2019 and repeated in January 2020 showed they had failed to prescribe high-risk antibiotics in line with Public Health England guidance.</p> <p>We checked the fridge temperatures used to store vaccines and found all were within acceptable temperature ranges.</p>	

## Effective

**Rating: Not rated**

**Effective needs assessment, care and treatment**

**Patients' needs were not assessed, and care and treatment was not delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
Patients' treatment was regularly reviewed and updated.	N
Explanation of any answers and additional evidence: We found patients treatment was not regularly reviewed in a systematic way relating to the management of medicines.	

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	52	61	85.2%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	48	59	81.4%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	48	59	81.4%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	48	59	81.4%	Below 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

### Any additional evidence or comments

We asked to review the unverified Public Health England data for the practice's performance in the above areas. We found a decline in all four areas, for example:

- Unverified Public Health England data for the period 1 April 2019 to 31 March 2020 showing the percentage of children aged one year who had completed a primary course of immunisation for diphtheria, tetanus, polio, pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) was 35%. Published Public Health England data for the previous period 1 April 2018 to March 2019 was 85.2%. This indicates a decline in clinical performance of 50.2% and failure to meet the WHO target of 95%.
- Unverified Public Health England data for the period 1 April 2019 to 31 March 2020 showed that the percentage of children aged two years who had received their booster immunisation for pneumococcal infection was 36%. Published NHS England data for the previous period 1 April 2018 to March 2019 was 81.4%. This indicates a decline in clinical performance of 45.4% and that the practice failed to achieve the WHO target of 95%.
- Unverified Public Health England data for the period 1 April 2019 to 31 March 2020 shows that the percentage of children aged two years who had received their immunisation for haemophilus influenza type b (Hib) and meningitis C was 37%. Published Public Health England data for the previous period 1 April 2018 to March 2019 was 81.4%. This indicates a decline in clinical performance of 44.4% and performance remained below the WHO target of 95%.
- Unverified Public Health England data for the period 1 April 2019 to 31 March 2020 shows that the percentage of children aged two years who had received immunisation for measles, mumps and rubella was 37%. Published Public Health England data for the previous period 1 April 2018 to March 2019 was 81.4%. This indicates a decline in clinical performance of 44.4% and below the WHO target of 95%.

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 64). (Snapshot date: 31/12/2019) (Public Health England)	59.2%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	61.9%	72.5%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	45.5%	55.4%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2018 to 31/03/2019) (PHE)	62.9%	68.0%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	61.1%	44.5%	53.8%	No statistical variation



### Any additional evidence or comments

We asked to review the unverified Public Health England data for the practice's performance in the above areas. We found a decline in their performance in three areas, for example;

- Unverified Public Health England data for the period 31 March 2019 to 30 June 2020 showed that 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 the service achieved 57% and screening within 5.5 years for women aged 50 to 64) was 71%. Overall this meant the service achieved 64%. Published Public Health England data for the previous period 1 April 2018 to March 2019 was 62%. This indicates an improvement of clinical performance of 2% but remains below the WHO target of 80%.
- Unverified Public Health England data for the period 1 April 2019 to 31 March 2020 showed that the percentage of females, 50-70, screened for breast cancer in the last 36 months was 11%. Published Public Health England data for the previous period 1 April 2018 to March 2019 was 61.9%. This indicates a decline in clinical performance of 50.9%.
- Unverified Public Health England data for the period 1 April 2018 to 31 March 2019 showed that the percentage of persons, 60-69, screened for bowel cancer in the last 30 months was 46%. Published Public Health England data for the previous period 1 April 2017 to March 2018 was 33%. This indicates a decline in clinical performance of 13%.

We did find an indication of improvement in the practice's management of patients with cancer, diagnosed within the preceding 15 months, who had a patient review recorded as occurring within six months of the date of diagnosis. Unverified Public Health England data for the period 1 April 2019 to 31 March 2020 showed the practice achieved 96% an increase of 33.1% on the previous year.

### Monitoring care and treatment

**The practice had not implemented a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.**

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	N
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	N
Quality improvement activity was targeted at the areas where there were concerns.	N

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

We asked the practice for evidence of clinical audits carried out since our last inspection in January 2020. The practice provided records that showed an initial audit of the prescribing of high-risk antibiotics had been conducted on 24 October 2019. Results from the audit showed that in the three months prior to the audit date: 45% of cephalosporin prescriptions were in line with Public Health England guidance; 62.5% of quinolones prescriptions were in line with Public Health England guidance; 26% of co-amoxiclav prescriptions were in line with Public Health England guidance. Records showed that the practice had identified action that needed to be taken in relation to the prescribing of high-risk antibiotics. However,

when they repeated the audit on 11 June 2020 and it showed only minor improvements. Results showed that in the three months prior to the audit carried out on 11 June 2020: 59% of cephalosporin prescriptions were now in line with Public Health England guidance (an improvement of 14%); 56% of quinolones prescriptions were now in line with Public Health England guidance (a deterioration of 6.5%); 45% of co-amoxiclav prescriptions were in line with Public Health England guidance (an improvement of 19%). We looked but could not find any action plan to further improve compliance with Public Health England guidance on prescription of these high-risk medicines or any plans that the audit was to be repeated again to provide ongoing monitoring.

## Effective staffing

**The practice was unable to demonstrate that all staff had the skills, knowledge and experience to carry out their roles.**

	Y/N/Partial
The learning and development needs of staff were assessed.	N
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.	N
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N
<p>Explanation of any answers and additional evidence:</p> <p>The practice was required, as a result of the CQC warning notice, to complete staff appraisals by 13 May 2020. We specifically identified six staff members this related to. We found five staff members had not received an appraisal by 13 May 2020, many were completed in June 2020. Two members of the clinical team had not received an appraisal within the last two years. This is contrary to the requirements of the Nursing and Midwifery Council that stipulates all members should receive regular performance appraisals (at least annually), during which their training needs should be identified. We found one staff member did not have an appraisal but a self-evaluation that contained two narratives, written in the first and third person. Where performance issues were identified there was no evidence of support being provided to the staff member or action plan in place to improve their performance.</p> <p>During our earlier inspection conducted in January 2020 we found five staff members had failed to undertake required training such as basic life support training, recognition and management of severe infections and infection prevention control training. We required the training to be completed by 13 May 2020. Our inspection in July 2020 found a GP still had not conducted practical basic life support training, another GP had not completed infection prevention control training and other outstanding training was completed in June and July 2020.</p>	

## Well-led

## Rating: No rating

### Leadership capacity and capability

**Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Explanation of any answers and additional evidence: The provider had not addressed and resolved all risks identified within the enforcement notice issued following the January 2020 inspection.	

### Governance arrangements

**The overall governance arrangements were ineffective.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	N
Explanation of any answers and additional evidence: The practice had appointed lead roles within their management team. Despite this, we found incomplete record keeping and poor care provided. Staffing levels were minimal and staff continued to report unmanageable high workload.	

### Managing risks, issues and performance

**The practice did not have clear and effective processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	N
There was a systematic programme of clinical and internal audit.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
When considering service developments or changes, the impact on quality and sustainability was assessed.	N
Explanation of any answers and additional evidence: We found systemic failing across the inspection domains demonstrating an absence of leadership and oversight necessary to ensure a safe, effective and well led service. For example, the practice failed to	

meet the requirements detailed within the warning notice by 13 May 2020. Where performance issues had been identified in appraisals we found no action plans to support improvements in performance. A members of the clinical team had failed to receive practice emergency life support training. We found clinical audits continued to show poor clinical compliance with guidance, infection prevention control audits had not been completed, risks identified in fire drills had not been addressed to mitigate a reoccurrence.

## Appropriate and accurate information

### The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	N
Performance information was used to hold staff and management to account.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
Explanation of any answers and additional evidence:	
<p>The practice was inspected in January 2020 and risks were identified with the service. These resulted in the issuing of an enforcement notice to the provider requiring compliance by 13 May 2020. On reinspection on 10 July 2020 we found a number of areas where the provider had failed to meet the requirements. They had not demonstrated effective arrangements were in place to manage and mitigate risks to patients.</p>	

## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.