

# Care Quality Commission

## Inspection Evidence Table

### Chapel Street Medical Centre (1-1145580080)

Inspection date: **21 October 2021**

## Overall rating: Requires Improvement

This inspection was undertaken to confirm that the practice had carried out their plan to meet the legal requirements regarding the breaches in regulation set out in warning notices we issued to the provider in relation to Regulation 17 Good Governance.

At the last inspection in June 2021 we rated the practice as Requires Improvement overall. This will remain unchanged until we undertake a further full comprehensive inspection.

## Safe

## Rating: Not rated

### Safety systems and processes

**The practice had improved systems, practices and processes to keep people safe and safeguarded from abuse.**

Safeguarding	Y/N/Partial
Partners and staff were trained to appropriate levels for their role.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Explanation of any answers and additional evidence: At the previous inspection in June 2021 we found that staff training was not being effectively monitored. The practice was not able to demonstrate that all staff had completed the required training for their role. During this inspection in October 2021, we found that the practice had improved their systems to monitor staff training and that all staff except one had completed necessary training. The practice took immediate action to arrange training for the staff member. The practice was able to provide some assurance to mitigate the level of risk, the staff member had received a local induction that included fire safety procedures for the practice. Following the inspection, the practice provided evidence to show the staff member had completed the relevant training before the inspection and told us they had improved their monitoring system further so that training could be more effectively monitored.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Explanation of any answers and additional evidence: At the previous inspection in June 2021 the practice was unable to demonstrate they had suitable	

assurances in place in line with safer recruitment.

During this inspection in October 2021 we found the practice had improved their recruitment processes. Staff files we viewed had been updated and mostly contained relevant information. We found that new processes had been implemented to help ensure files were complete. Where we found gaps in information, the practice was advised of this. They told us they would amend their processes further to ensure this information was obtained in the future.

#### **Information to deliver safe care and treatment**

**Staff had the information they needed to deliver safe care and treatment.**

	Y/N/Partial
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information 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
Explanation of any answers and additional evidence: Records that we reviewed during this inspection showed that appropriate blood results had been requested and results were acted upon appropriately.	

#### **Appropriate and safe use of medicines**

**The practice had improved systems for the appropriate and safe use of medicines, including medicines optimisation**

Medicines management	Y/N/Partial
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
Explanation of any answers and additional evidence: At the previous inspection in June 2021 we found the practice did not have an effective system in place to manage patients on high risk medicines. During this inspection in October 2021, we found the practice had put a system in place for monitoring high risk medicines following discussions with the Clinical Commissioning Group, the practice-based pharmacist and the Primary Care Network Clinical Director. The practice with support from an external provider had put in place a written protocol for high risk medicines monitoring. The practice showed us evidence of how they monitored the process and told us of the process they used to ensure that patients were re-called for monitoring checks. We saw from records that we reviewed, the practice used alerts to act as reminders to help with safer prescribing. Prescriptions that we viewed contained information on what monitoring was needed. We saw evidence of the practice contacting patients to ask them to attend for the required blood tests.	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found the practice did not have an effective system in place to manage safety alerts. At this inspection in October 2021 we found the practice had acted upon the warning notices and they could demonstrate they had improved their systems and processes for managing safety alerts.</p> <p>We found the practice had implemented a process for managing safety alerts. They recorded any new safety alerts and the actions taken in response to these. From records that we reviewed we saw that most safety alert information was being actioned.</p> <p>We saw evidence of pop up alerts added to patients records to remind clinicians of the action that was needed.</p> <p>We found the practice had taken action to address the issues identified at the last inspection regarding a specific safety alert and had established a monthly search to check for any patients prescribed this combination of medications. However, the practice was not able to demonstrate they had a process in place to ensure all historical safety alerts were monitored and actioned.</p> <p>Where we found gaps, we discussed these with the practice. The practice told us they would be amending their processes immediately to include all historical safety alerts and contacting all relevant patients.</p>	



## Effective

## Not rated

### Effective needs assessment, care and treatment

**Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>During the last inspection in June 2021 we found that patients coded as pre-diabetic on the record system were not always monitored appropriately.</p> <p>At this inspection in October 2021 we found the practice had improved their systems to monitor and manage patients with diabetes or those patients at risk of diabetes.</p> <p>Following the last inspection, the practice has established a Pre-diabetic policy to ensure that pre-diabetic patient records were coded correctly, and yearly blood sugar monitoring checks were arranged.</p> <p>We spoke with the practice about reviewing codes for diabetic patients further, so that they could be more effectively monitored. The practice told us they had taken immediate action following the inspection, however, they would also seek further guidance from the Clinical Commissioning Group on this.</p>	

## Well-led

**Rating: Not rated**

### Leadership capacity and capability

**Leaders were being supported by an external provider to help deliver high quality sustainable care.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Explanation of any answers and additional evidence: The practice was being supported by an external provider to implement the changes that were needed following the warning notice. We found the practice had responded appropriately to our concerns from the last inspection, and they took immediate action following this inspection to further improve governance processes.	

### Governance arrangements

**The practice had reviewed and improved governance arrangements.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
Explanation of any answers and additional evidence: Following our previous inspection in June 2021, the practice, with the support of an external provider had reviewed and improved their governance systems. This included improving systems to manage high risk medicines, safety alerts, staff training and recruitment processes.	

### Continuous improvement and innovation

**There was evidence of systems and processes for learning and improvement.**

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: The practice had taken appropriate action following our previous inspection in June 2021 to meet the legal requirements regarding the breaches in regulation set out in warning notices we issued to the provider in relation to Regulation 17 Good Governance. The practice continued to work with an external provider to make further improvements to help deliver safe and effective care.	

## 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.
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- $\text{‰}$  = per thousand.