

Inspection Evidence Table

Jenner Healthcare

(1-549500391)

Inspection Date: 11/07/2023

Date of data download: 22/06/2023

Overall rating: Good

Safe

Rating: Requires improvement

At our last inspection in May 2022, we rated the practice as Requires Improvement for providing safe services because:

- The practice was not able to evidence that all patients had a structured and comprehensive medicines review. Although we found record keeping was generally of sufficient detail, we found some examples where the relevant diagnosis was not coded correctly and subsequently patients were not receiving the required treatment.
- We found a historical patient safety alert relating to a combination of medicines which reduces their effectiveness had not been incorporated into good practice.
- We found the practice did not have full oversight of the recruitment documentation for staff to be fully assured required checks had been undertaken and documented in a timely manner.

On this inspection we found some previous concerns identified had been improved however, we identified previous concerns identified continued to be present. At this inspection the practice was rated as requires improvement for providing safe services because:

- The practice did not always evidence that all patients had a structured and comprehensive medicines review.
- The practice could not evidence that all patients with long term conditions were being reviewed effectively due to coding and linking diagnosis with treatment. This meant patients were not always receiving effective treatment when reviewed.
- The practice could not evidence that all medicines were prescribed safely to patients.
- We found a historical alert relating to a combination of medicines which reduced their effectiveness had not been acted upon.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	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
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: The practice had monthly safeguarding meetings with school nurses and health visitors where they discussed safeguarding within the practice. These meetings then informed a further discussion held with the clinical team to discuss cases and take action if required. A midwife worked at the practice and regular discussions regarding safeguarding occurred.	

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 UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
Explanation of any answers and additional evidence: At the previous inspection in April 2022, we found gaps in recruitment checks. At this inspection we found the practices systems and processes had strengthened. We found the practice had oversight of recruitment documentation and that the systems in place were effective when we reviewed staff files that had been recruited since the previous inspection.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: Thorney: 27/06/2023	Y

Eye: 27/06/2023 Whittlesey: 27/06/2023	
There was a fire procedure.	Y
Date of fire risk assessment: Thorney: 02/11/2022 Eye: 02/11/2022 Whittlesey: 15/03/2023	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice provided evidence of risk assessments carried out across all locations. Some actions were identified during these assessments and completed, this included the need for new elbow taps at the Whittlesey location.</p> <p>Further actions had been identified in respect of the fire risk assessment included replacing a faulty fire blanket at the Thorney location. This action had been completed upon inspection.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: Thorney: 01/05/2023 Eye: 23/06/2023 Whittlesey: 25/01/2023	Y
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
<p>Explanation of any answers and additional evidence:</p> <p>During the inspection we found the location we visited to be visibly clean, tidy and well maintained. We spoke to the infection control lead during the inspection process and found they were knowledgeable and trained for their role. Actions had been completed following the recent infection prevention and control audit which included putting up sharps policy posters and wall mounted sharps bins.</p>	

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
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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
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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 were enough staff to provide appointments and prevent staff from working excessive hours.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff feedback during the inspection highlighted more staff were needed to cover busy periods. Practice leaders were aware of this and had ongoing recruitment drives. Recent recruitment included 2 GPs, 2 nurses and a health care assistant. However, staff were able to cover various positions within their scope around the practice, and locums were used when needed.</p>	

Information to deliver safe care and treatment.

Staff did not always 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.	Partial
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.	Partial
Referrals to specialist services were documented, contained the required information 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.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>On the day of the inspection, we carried out a suite of searches on the practice's clinical system. We reviewed some of these search results and looked at a selection of patient medical records. We found some patients had not received appropriate and timely care and treatment.</p> <p>We found the medical records did not always contain sufficient information to enable clinical staff to evidence safe decision making. Although there was not a backlog of medical records waiting to be summarised, we found the practice's systems and processes to ensure medical information was added and coded consistently and correctly was not effective. Patients had not received appropriate follow up care because of these shortfalls. The lack of correct and consistent record keeping did not give assurance that other clinical staff or health professionals would be able to access patient information in order for them to provide appropriate clinical care. The practice system to review test results showed there was no backlog of results to review.</p>	

However, we found evidence of patients with results who had not been followed up appropriately or in a timely way because of the poor systems and processes in place. For example, we found 500 patients with a potentially missed diagnosis because the test results indicated they may have chronic kidney disease, but this had not been correctly coded nor added to the recall system. We reviewed 5 of these patient records and found all 5 had a missed diagnosis of chronic kidney disease.

Appropriate and safe use of medicines

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

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	1.31	0.94	0.91	Tending towards variation (negative)
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). (01/04/2022 to 31/03/2023) (NHSBSA)	14.6%	9.9%	7.8%	Significant variation (negative)
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 (01/10/2022 to 31/03/2023) (NHSBSA)	5.51	5.15	5.23	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	211.2‰	121.8‰	129.8‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.73	0.56	0.55	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	7.9‰	5.9‰	6.8‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

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 effective medicines reviews for patients on repeat medicines.	Y
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.	Y
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 ¹
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N ²
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement 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 ³
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
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 UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ol style="list-style-type: none"> 1. With the consent of the practice, we undertook clinical searches relating to high-risk medicines that required ongoing monitoring and identified 70 patients who were prescribed methotrexate, of which we found 1 patient did not appear to have had the required monitoring in the last 6 months. We reviewed this patient record and found that they were last monitored 7 months ago. The practice responded to this immediately and the patient was contacted and booked in, which we saw evidence of as part of our site visit to the practice. <p>Another clinical search identified 10 out of 59 patients prescribed a potassium sparing diuretic who had not had the required monitoring. We reviewed 5 patient records and found that 3 patients' medication dose was stable so did not require monitoring and 2 patients were being monitored by secondary care.</p> <ol style="list-style-type: none"> 2. We identified areas of risk relating to controlled drug prescribing. We identified 261 patients out of 475 prescribed gabapentinoids who had not had the required monitoring within the last 12 months. We reviewed 5 patient records and found 4 patients were overdue an annual medication review, 3 of which were also overdue their annual medication review. One patient we reviewed was overdue their monitoring by a day. On the day of inspection, the practice provided an action plan and started to review these patients. 	

3. The practice had undertaken an antibiotic audit to assess prescribing of antibiotics against the recommendations made in the local antimicrobial treatment guidelines. The first cycle in June 2022 identified 79% of patients were prescribed appropriately in line with guidance. The practice identified areas of improvement including the need to use prescribing templates on the system, which were discussed in clinical meetings for awareness. A second cycle was conducted in February 2023 which identified 84% of patients were prescribed appropriately in line with guidance. The practice was happy with their improvements and further discussions were held in clinical meetings to reiterate importance of using the template and adhering to guidelines. The practice planned on repeating the audit every 6 months and the findings would be reported to prescribers for discussion and improvement.

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	NA
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Y
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y

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.	Y
Number of events recorded in last 12 months: 22	Y
Number of events that required action: 14	Y
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed the practice records for recording significant events and outcomes. We found the practice had a robust system to ensure events and learning were shared with all team members which was evidence in meeting minutes.</p>	

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

Event	Specific action taken
Pathology samples missed collection	Take extra care when processing samples to ensure they have the correct documents attached and placed in the basket.
Disposal of clinical waste. Needle found in clinical waste bin,	No staff were injured, and waste management policy reiterated to staff.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial ¹
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. As part of the inspection, we used clinical searches to review the practice system to ensure action on safety alerts. Generally, we found the system was well managed. We identified 49 patients prescribed a medicine which required regular blood pressure readings. We identified 3 patients out of 49 that hadn't had the required monitoring. 1 patient had an upcoming appointment to review this medication, but 2 patients were potentially at risk due to lack of monitoring. On the day of inspection, the practice could evidence these patients had been booked in for reviews. 2. The practice told us patient safety alerts were received by the management team and pharmacy team via email and via an online system. Staff were prompted to acknowledge receipt of the alert. The management team and pharmacy team would then conduct searches to understand what action was needed and alert staff, all alerts were reviewed at clinical meetings where actions were discussed. 	

Governance arrangements

There were clear responsibilities and roles however, some systems did not support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Explanation of any answers and additional evidence: As discussed in the safe domain we found some of the governance structures were not wholly effective and had not been sufficiently reviewed nor monitored by the clinical leaders. However, we found improved governance systems for recruitment, training of staff and monitoring of high-risk medicines.	

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.	Partial
There were processes to manage performance.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Explanation of any answers and additional evidence: As discussed in the safe domain the assurance systems in place had failed to identify the risks such as lack of comprehensive medicines reviews, clinical coding and safety alerts. These processes had failed to manage performance and the data could not be relied upon. These systems if effective would have supported identifying shortfalls and mitigating risks to patients. However, we found effective processes for infection prevention and control audits with actions completed in a timely manner, the practice also evidenced regular discussions regarding vulnerable patients both internally and with external organisations to ensure risk was managed appropriately.	

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.
- **UKHSA:** UK Health and Security Agency.
- **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.
- ‰ = per thousand.