

# Care Quality Commission

## Inspection Evidence Table

### Vista Road Surgery (1-4254610136)

Inspection date: 8<sup>th</sup> July 2021

Date of data download: 28 June 2021

## Overall rating: Good

At the last inspection in December 2019 the practice was rated Good overall and Requires Improvement for providing Safe services. The practice is now rated Good for safe and remains Good overall.

## Safe

## Rating: Good

At the previous inspection in December 2019 the service was rated requires improvement in safe because breaches were found in; Regulations 12 HSCA (RA) Regulations 2014 Safe care and treatment and Regulations 19 HSCA (RA) Regulations 2014 Fit and proper persons employed.

We found that systems in place had not ensured all infection prevention and control measures had been completed to an appropriate standard; medicines management needed to be improved; the process for handling and monitoring test results and letters from secondary care were not robust and the systems to ensure staff were fit to carry out their roles needed to be developed and strengthened.

At this follow-up review we found that action had been taken to become compliant in these aspects of the safe key question and so we rated the service as Good in safe.

### Safety systems and processes

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

Safeguarding	Y/N/Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Explanation of any answers and additional evidence: At the previous inspection in December 2019 we found that Disclosure and barring service checks had not been completed for new recruits prior to them working at the practice. At this follow-up review information from the provider could demonstrate that all the required recruitment checks including the	

Safeguarding	Y/N/Partial
disclosure and barring check had been completed for the most recent recruit before they took up their post. The recruitment policy confirmed systems were in place to support and sustain this process.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection in December 2019 we found that the provider had not ensured staff were fit for the roles they occupied, pre-employment health checks were not completed, and health declarations were not sought. At this follow-up review the provider had ensured information about the health of newly appointed staff was available prior to them starting in their role.</p> <p>At the previous inspection in December 2019 processes were not in place to ensure all staff had been immunised in keeping with best practice standards. At this follow-up review, documents confirmed that checks had been made and steps taken to ensure all staff including new recruits had the required Immunisations.</p> <p>At the previous inspection in December 2019 systems were needed to ensure clinical and nursing staff were correctly registered to carry out their roles. At this follow-up review, we found that policies and procedures had been introduced to ensure the registration status of staff was periodically checked and confirmed as up to date.</p>	

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met.**

	Y/N/Partial
The practice had acted on any issues identified in infection prevention and control audits.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection in December 2019 we found that the provider was not aware of all the findings in the 2019 Legionella report and some recommendations had not been actioned. At this follow-up review, evidence was provided which confirmed all the recommendations in the legionella report had been actioned. A follow-up Legionella risk assessment and inspection had been completed which confirmed water management was safe.</p> <p>At the previous inspection the provider was asked to consider implementing cleaning schedules to strengthen the cleaning policy. At this review cleaning rosters had been introduced by the provider and used to monitor staff compliance with the cleaning regime.</p>	

## Information to deliver safe care and treatment

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

	Y/N/Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection processes to ensure appropriate clinical oversight of test results were not in place. At this follow-up review evidence was presented to demonstrate that responses to test results and patient outcomes were reviewed and periodically monitored with individual clinical and non-clinical staff and at clinical meetings.</p> <p>At the previous inspection we found the guidance for processing letters and test results were unclear. At this follow-up review, the process for handling letters, test results and communication from secondary health care providers had been clarified and a robust procedure which included the use of a flow-chart had been introduced.</p>	

## 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) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.77	0.79	0.70	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2020 to 31/03/2021) (NHSBSA)	9.7%	7.6%	10.2%	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 (01/10/2020 to 31/03/2021) (NHSBSA)	5.62	5.73	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	194.2‰	256.4‰	126.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	1.17	1.28	0.66	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	8.7‰	9.2‰	6.7‰	No statistical variation

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

Medicines management	Y/N/Partial
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes

Medicines management	Y/N/Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection in December 2019 we found that processes for supporting and ensuring the safe use of medicines were not robust because appropriate patient group directions for medicines prescribed by non-clinical staff were not in place; blank prescriptions were not held securely; the monitoring of medicines competencies were not formalised and the emergency response medicines and kit were not well-managed. At the previous inspection the provider was also asked to consider taking action to ensure the medicine fridge could not be accidentally disconnected from the mains electricity supply.</p> <p>At this follow-up review these matters had been resolved:</p> <ul style="list-style-type: none"> <li>• The practice manager provided up to date patient group directions (PGDs) documents which were correctly completed and met the legal framework allowing the named registered healthcare professionals to supply and, or, administer medicines. (PGDs are written instructions for the supply or administration of medicines such as vaccines, approved by the NHS, to groups of patients who may not be individually identified before presentation for treatment.)</li> <li>• Processes were in place to ensure PGDs for vaccinations were signed by staff with the correct authorisation and these were up to date and timely.</li> <li>• There were now systems in place to periodically review the prescribing competencies of nurse prescribers.</li> <li>• The provider had reviewed, and risk assessed emergency medicines available to ensure that all items suggested in best practice guidance were provided and action had been taken to ensure emergency response equipment would always be in good repair.</li> <li>• The medicines refrigerator had been hardwired to ensure it could not be switched off accidentally.</li> </ul>	

#### 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 considered 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 considering the types of people who will be receiving that treatment.
- **\*PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
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- $\text{‰}$  = per thousand.