

Inspection Evidence Table

Old Henry Street Medical Centre

(1-547623840)

Inspection Date: 5 July 2023

Overall rating: Good

We previously carried out an inspection at Old Henry Street Medical Centre on 2 August 2022. Overall, the practice was rated as Good overall with the following key question ratings:

Safe – Requires Improvement
Effective -Good (rating awarded at the inspection 2 August 2022).
Caring – Good (rating awarded at the inspection 8 February 2018).
Responsive – Good (rating awarded at the inspection 8 February 2018)
Well-led -Good (rating awarded at the inspection 2 August 2022).

At this focussed inspection, on 5 July 2023, we found that improvements had been made and the key question safe has been rated good. The overall rating is therefore good.

Safe

Rating: Good

At the inspection on 2 August 2022 the key question of safe had been rated requires improvement. The system for ensuring patients had the required monitoring when prescribed certain medicines was not fully effective. Not all Ardens alerts had been actioned. Ardens includes MHRA drug safety alerts, NICE clinical guidance, and other safety alerts built into it. Clinical data is constantly monitored, and alerts are displayed where a safety issue arises. These alerts work for all staff within a practice and work in real time.

At this inspection, on 5 July 2023, we found improvement in all these areas and the key question is now rated good.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff had access to safeguarding e-learning modules and all clinical staff members had completed safeguarding training to the appropriate level for their role. • There were safeguarding policies and procedures in place for both children and adults and protocols were in place for patients who did not attend appointments. • The lead GP in the practice attended local adult safeguarding and child protection meetings when required. • The practice had reconciled their safeguarding register by contacting the local safeguarding team to ensure the list of patients they held was the same as in the practice. 	

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

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: 8 August 2022	Y
There was a fire procedure.	Y
Date of fire risk assessment: 2 November 2022	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice completed a premises and security risk assessment on 1 February 2023. This identified several risk areas. This included replacing light fittings, adjustable chairs in reception and consulting rooms and also fitting antiglare covering to the reception screen. This had all been completed.</p> <p>Portable appliance testing (PAT) was completed on 28 February 2023.</p>	

Equipment was last calibrated on 20 October 2022.

NHS Property Services provided a range of facilities management services to keep the building in good order & repaired. The services include:

- Repairs and maintenance of the building fabric.
- Repairs and maintenance of the external areas of the building.
- Maintenance of the electrical & mechanical installations.
- Ensuring premises compliance to statutory requirements.

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: 22 June 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• All the staff we spoke with demonstrated an awareness of appropriate infection prevention and control (IPC) standards.• There were cleaning schedules in place that were monitored by the practice.• There was evidence to show action had been taken following the last IPC audit and regular hand hygiene audits were carried out.• Risk assessments and audits had been carried out to ensure services such as flu vaccinations, were carried out in a safe space and followed IPC good practice guidance.	

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

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had a system in place that indicated the minimum number of staff required and was planned on a monthly basis. In the unexpected absence of GPs or other staff then cover was provided by other members of the practice team. 	

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. 1	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
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.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Review of patient records in relation to the clinical searches identified that records were managed in a way to protect patients. The practice had established referral systems and processes. All test results were reviewed and actioned by a GP. 	

Appropriate and safe use of medicines

The practice had 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	1.18	1.05	0.91	No statistical variation

Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)				
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)	8.5%	8.5%	7.8%	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 (01/10/2022 to 31/03/2023) (NHSBSA)	5.46	5.90	5.23	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	281.5‰	187.2‰	129.8‰	Tending towards variation (negative)
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)	0.76	0.57	0.55	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	12.0‰	9.1‰	6.8‰	Tending towards variation (negative)

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. 1	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. 2	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 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
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:</p> <ul style="list-style-type: none"> The practice continually reviewed their systems and processes for the administration and supply of medicines, and regular reviews for repeat prescribing for the benefit of the patient population. There were medicine management and prescribing policies and procedures in place including a home visit policy. As part of the inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor without visiting the practice. The records of patients prescribed certain high-risk medicines were checked to ensure the required monitoring was taking place. These searches were visible to the practice. At the previous inspection on 2 August 2022 we found some patients prescribed high risk medicines such as diuretics and levothyroxine had not received the required monitoring. Also some patients prescribed Angiotensin-converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (used to lower blood pressure), did not have up to date monitoring. There were some medicine reviews were overdue for patients prescribed four or more medicines and Ardens alerts were not always actioned. At this inspection, the records we examined provided evidence that most patients prescribed high risk medicines had been monitored appropriately. Of those where monitoring was overdue, we saw the plan in place to arrange the required checks for patients. The practice had a system in place to note the prescriptions of patients prescribed high risk medicines to highlight they must have blood tests at the required intervals, and repeat prescriptions would be issued if the required tests had taken place. We noted that the recording of patient medicine reviews provided consistent and comprehensive information regarding the patient and their prescribed medicines. The practice had implemented a robust system to ensure that Ardens alerts were actioned. 	

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:	13
Number of events that required action:	13
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> All significant events were reviewed, discussed at meetings, and all actions carried out. If learning points were identified these were cascaded to appropriate staff to prevent recurrence. The significant events we reviewed indicated that the practice was responsive to the needs of vulnerable patients and identified the need for improved communication between internal staff and other health and social care professionals if required. 	

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: <ul style="list-style-type: none"> The practice had a clear and timely process in place to ensure safety alerts were reviewed and a record was maintained of the action taken in response to alerts where appropriate. Safety alerts were circulated to the GPs. They decided if action was required and ensured that any actions were cascaded to the appropriate staff member. 	

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.