Care Quality Commission

Inspection Evidence Table

Special Allocation Scheme (Camden, Islington and Haringey) (1-4565460330)

Inspection date: 20 November 2018

Safe

Safety systems and processes

Safeguarding	Y/N
There was a lead member of staff for safeguarding processes and procedures.	Y
Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Policies were in place covering adult and child safeguarding.	Y
Policies were updated and reviewed and accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs)	Y
Information about patients at risk was shared with other agencies in a timely way.	Y
Systems were in place to highlight vulnerable patients on record. There was a risk register of specific patients	Y
Disclosure and Barring Service checks were undertaken where required	Y

The provider had up to date policies, last reviewed in February 2018 which had been updated to include guidance on female genital mutilation (FGM). Although children were not seen by the service, the provider had appropriate safeguarding processes relating to child protection, including a policy last reviewed in July 2018. Staff had received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents at all the services operated by the provider were available to staff. We saw minutes confirming safeguarding issues were discussed at clinical governance meetings.

The provider had a policy on chaperoning, which had been reviewed and updated in October 2018. Posters at the location informed patients of the availability of chaperones. Staff who acted as chaperones were trained for their role and had received a DBS check.

Recruitment Systems	Y/N
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y

Systems were in place to ensure the registration of clinical staff was checked and regularly monitored.	Y
Staff who require medical indemnity insurance had it in place	Y

Safety Records	Y/N
There was a record of portable appliance testing or visual inspection by a competent person Date of last inspection/Test:	Y 6/7/18
There was a record of equipment calibration Date of last calibration:	Y 9/1/18
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals	Y
Fire procedure in place	Y
Fire extinguisher checks	Y
Fire drills and logs	Y
Fire alarm checks	Y
Fire training for staff	Y
Fire marshals	Y
Fire risk assessment Date of completion	Y 18/7/18
Actions were identified and completed.	Y
Health and safety Premises/security risk assessment/Health and safety risk assessment? Date of last assessment:	Y 27/4/18

Infection control	Y/N
Risk assessment and policy in place Date of last infection control audit: (Premises landlord) Date of last infection control audit: (Provider) The provider acted on any issues identified	Y 24/10/17 1/11/18 Y
The arrangements for managing waste and clinical specimens kept people safe?	Y
The provider's infection prevention and control (IPC) policy had been reviewed and updated in March 2018. There were named leads and deputies responsible for IPC issues. All staff had received appropriate IPC training. The premises landlord had carried out a full annual IPC audit in October 2017.	

It was due to be repeated around the time of our inspection. The landlord was responsible for cleaning, which was done in accordance with planned schedules, was logged and monitored on a monthly basis. The provider also carried out its own audits of the clinical rooms it shared for the service. We saw that one had been conducted on 1 November 2018, with a minor action being escalated to the premises cleaners. The provider had an up to date policy on the management of sharps and guidance was available regarding needlestick injuries.

A risk assessment in respect of legionella, a bacterium which can infect water systems in buildings, had been carried out by the landlord, supported by monthly and annual inspections together with regular sample analysis. We saw that the next full risk assessment was programmed for January 2019.

Risks to patients

Question	Y/N
There was an effective approach to managing staff absences and busy periods.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans were developed in line with national guidance.	Y
Staff knew how to respond to emergency situations.	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
In addition, there was a process in the practice for urgent clinician review of such patients.	Y
The practice had equipment available to enable assessment of patients with presumed sepsis.	Y
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y

The one reception staff member had recently been appointed and had not yet been given specific training, but this was planned for shortly after our inspection. There were additional receptionists and staff from other services using the premises, who were familiar with the sepsis protocols.

The provider had a detailed standard operating procedure relating to emergency medical response.

Information to deliver safe care and treatment

Question	Y/N
Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
The practice had a documented approach to the management of test results and this was managed in a timely manner.	Y

The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y

Appropriate and safe use of medicines

Medicines Management	Y/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.	Y
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	N/A
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	Y
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, audits for unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were systems for the safe ordering, checks on receipt, storage, administration, balance checks and disposal of these medicines in line with national guidance.	N/A
Up to date local prescribing guidelines were in use.	Y
Clinical staff were able to access a local microbiologist for advice.	Y
For remote or online prescribing there were effective protocols in place for identifying and verifying the patient in line with General Medical Council guidance.	N/A
The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen on site.	Y
The practice had a defibrillator.	Y
Both were checked regularly and this was recorded.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	N/A
Regular medicines and prescribing audits were conducted by the provider's employed pharmacist. The provider had up to date policies on prescribing and prescription security.	

Track record on safety and lessons learned and improvements made

Significant events	Y/N
There was a system for recording and acting on significant events. Last reviewed and	Y

updated May 2018.	
Staff understood how to 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.	4
Number of events that required action	3

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

Event	Specific action taken
Records management	Learning shared across all services, regarding NHS email system.
Access	GPs reminded of contractual responsibilities.
Patient referred to service without prior risk assessment.	Staff now ensure risk assessment carried out before appointments are offered.

Safety Alerts	Y/N
There was a system for recording and acting on safety alerts	Y
Staff understand how to deal with alerts	Y

The provider had a protocol for handling safety alerts, last reviewed and updated in February 2018. Several of the provider's senior staff were registered to receive alerts from the NHS Central Alerting System. These were logged, reviewed by the Medical Director and distributed to location managers. Searches were conducted to identify any patients effected. We saw a detailed spreadsheet setting out 10 alerts issued by the Medicines and Healthcare products Regulatory Agency (MHRA) which had been processed and actioned in the last six months. The provider also received monthly bulletins from the Camden CCG containing updates of any alerts, which were processed in a similar way.

Effective

Effective needs assessment, care and treatment
The provider had an up to date protocol in place to ensure that care was provided in accordance with national and local guidelines, such as those issued by NICE and the local CCG. The service did not participate in QOF due to its specialist nature. However, there were regular reviews done internally and with the commissioners to ensure the effectiveness of the service.

Consent to care and treatment

Description of how the practice monitors that consent is sought appropriately
The provider had a detailed policy outlining the process for obtaining patients' consent to treatment. Regular clinical quality audits were conducted to monitor all aspects of patients' consultations.

Caring

Kindness, respect and compassion

CQC comments cards	
Total comments cards received	6
Number of CQC comments received which were positive about the service	6
Number of comments cards received which were mixed about the service	0
Number of CQC comments received which were negative about the service	0

Examples of feedback received:

Source	Feedback
Provider's patient survey	"Staff very helpful."
Comments cards	"Staff very friendly and professional."

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Y

Date of exercise	Summary of results
October 2018	The service had 47 patients registered. Eleven patients submitted feedback, which was consistently positive regarding their experience of the service.

Involvement in decisions about care and treatment

Examples of feedback received:

Source	Feedback
Provider's patient survey	All 11 respondents said they were involved as much as they wanted in decisions regarding their care.

and CQC comments cards	No negative observations were recorded on our comments cards.

Question	Y/N
Interpreter services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y

Carers	Narrative
How the practice supports carers	We saw information and guidance for carers and bereaved patients was available in the reception area. The provider also maintained a library of material on the shared drive, which staff could access and print for patients.
How the practice supports recently bereaved patients	

Privacy and dignity

Question	Y/N
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y

	Narrative
Arrangements to ensure confidentiality at the reception desk	The provider was aware of the need to maintain confidentiality, subject to appropriate safety arrangements and risk assessment. The premises were owned and operated by the local trust, providing specialist services. The facilities were appropriate to these and the service operated by the provider. Patients attended by appointment only, meaning there was rarely a queue of people waiting to be seen.

Question	Y/N
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y

Responsive

Responding to and meeting people's needs

Practice Opening Times	
Day	**Time**
Monday	Closed
Tuesday	1.00 pm – 4.00 pm
Wednesday	Closed
Thursday	9.00 am – 12.00 noon
Friday	Closed

Home visits	Y/N
The service had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention	Y
If yes, describe how this was done	
There was a standard operating procedure in respect of home visits. Each patient using the service had an individual risk assessment. Home visits could be arranged subject to these assessments and appropriate security staff being available, if necessary.	

Timely access to the service

Examples of feedback received from patients:

Source	Feedback
Provider's patient survey	"Easy to make an appointment", "Amazing service".

Listening and learning from complaints received

Complaints	
Number of complaints received in the last year.	3
Number of complaints we examined	3
Number of complaints we examined that were satisfactorily handled in a timely way	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman	0

Additional comments:
The provider had an up to date complaints policy, which included provision for an annual review. Complaints were monitored at regular governance meetings. A complaints leaflet was available for patents, and we saw guidance posters at the premises.

Example of how quality has improved in response to complaints
Improved liaison between security staff at the location and the provider's clinical and administrative teams. Patients' registration information reviewed.

Well-led

Leadership capacity and capability

Examples of how leadership, capacity and capability were demonstrated by the provider
Leaders had the capacity and skills to deliver high-quality, sustainable care. Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. Staff reported that they felt well led and part of a team. There was collaboration and support and a common focus on improving the quality of care and people's experiences Staff met regularly to discuss any issues or complex cases and to offer and receive peer support.

Vision and strategy

Provider's Vision and values
The provider had a clear vision and set of values that prioritised quality. Staff knew and understood the vision, values and strategy and their role in achieving them.

Culture

Examples that demonstrate that the provider has a culture of high-quality sustainable care
There were arrangements to deal with any behaviour inconsistent with the vision and values. Staff reported that they felt able to raise concerns without fear of retribution. There was a strong emphasis on the safety and well-being of staff. There were regular governance and clinical meetings reviewing performance and patient information.

Governance arrangements

Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care.	
Practice-specific policies	The provider had a raft of protocols and policies, which were reviewed and updated on a regular basis and communicated to all staff.
Other examples	There was an effective management structure, with clear roles and responsibilities for particular subject areas, such as safeguarding; infection control; health and safety; medicines management; and quality, incidents and complaints.

	Y/N
Staff were able to describe the governance arrangements	Y
Staff were clear on their roles and responsibilities	Y

Managing risks, issues and performance

Major incident planning	Y/N
Major incident plan in place – last reviewed and updated November 2018	Y
Staff trained in preparation for major incident	Y

Examples of actions taken to address risks identified within the service

Risk	Example of risk management activities
General	The provider had a detailed risk management policy, and risk assessment toolkit, last reviewed and updated in March 2018.
Patient safety	Ligature risk assessment carried at premises.
Staff security	Standard operating procedures in place and risk assessments carried out.

Appropriate and accurate information

Question	Y/N
Staff whose responsibilities include making statutory notifications understood what this entails.	Y

Engagement with patients, staff and external partners

Feedback from Patient Participation Group;

Feedback
N/A - The service did not operate a PPG

Any additional evidence
Feedback was sought from patients via comments slips following each appointment and by an annual survey. Subject to ongoing monitoring and review by managers. The feedback we saw was very positive. Staff reported they were involved in discussions regarding service improvements. The feedback we received from commissioners was positive.

Continuous improvement and innovation

Examples of improvements demonstrated as a result of clinical audits in past two years

Audit area	Improvement
Patient risk assessment / clinical quality audit (2-cycle) / Patient Rapport Audit	Risk assessment forms revised; improved record-keeping
Various prescribing audits (up to 3-cycles)	Confirmed prescribing in accordance with guidelines.

Any additional evidence
The provider had established the service from scratch November 2017 and it was operating safely and effectively. All staff receive individualised training opportunities which are discussed at their appraisals. There was protected learning time.

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 comparable, 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 comparable 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 Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	Comparable to other practices	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
6	No data	Null

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.

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:

http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease
- **PHE**: Public Health England
- **QOF**: Quality and Outcomes Framework (see https://qof.digital.nhs.uk/).
- **RCP**: Royal College of Physicians.
- **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.(See NHS Choices for more details).