Care Quality Commission

Inspection Evidence Table

Ashfield Medical Centre (1-565674714)

Inspection date: 5 November 2019

Date of data download: 05 November 2019

Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Safe Rating: Good

The practice was previously rated as requires improvement for providing safe services as we found there were ineffective systems and processes in place to reduce the risks to patient safety. In particular, systems to managing safety alerts needed strengthening.

During this inspection we saw evidence of improvement and the practice is now rated as good for providing safe services.

Safety systems and processes

The practice had 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.	Partial

Explanation of any answers and additional evidence:

During our inspection in January 2019, we found training records for non-clinical staff were incomplete. Some staff were overdue update training in safeguarding, information governance and fire safety. Staff we spoke with demonstrated a clear understanding of their responsibilities in relation to safeguarding and information governance. Immediately following our inspection, the practice advised a schedule for completion of all overdue training had been formulated. We were advised all staff would be up to date with training by the end of February 2019.

During this inspection, we saw improvements had been made to develop systems for monitoring staff training. For example, a member of the administrative team had been tasked with routinely checking staff had completed mandatory training and recording completion in a central file. We found all staff had completed the majority of required training. However, we found there were still gaps in safeguarding training for some staff. During our inspection, the practice advised that some staff had completed the training but that records had not been updated. Immediately following our inspection, we were sent evidence that staff files had been updated accordingly. The practice also advised that all non-clinical staff would be required to complete level 2 child safeguarding training as a minimum requirement. We

Safeguarding	Y/N/Partial
were advised applicable staff would be asked to complete this additional training as a matter of priority. Immediately following our inspection, we were sent evidence that almost all staff (with the exception of one individual on annual leave) had started or completed level 2 training for child safeguarding.	

Recruitment systems	Y/N/Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y

Explanation of any answers and additional evidence:

During our inspection on 22 January 2019, we saw appropriate records of vaccination history were requested and maintained for all clinical staff. However, records for non-clinical staff still needed strengthening. The practice had asked all non-clinical staff to complete self-assessment forms confirming their immunity status. However, blood tests to ensure accuracy and promote patient and staff safety had not been undertaken for non-clinical staff. A risk assessment to support this had not been undertaken. In response to feedback given on the day of inspection the practice advised all staff would receive appropriate blood tests by the end of February 2019.

During this inspection, we saw the practice had completed blood tests for all staff to check their immunity status. Staff were provided with additional vaccinations as required. Records of all staff vaccinations and immunity status were appropriately maintained. The practice had a policy for staff immunisations which clearly detailed the required vaccinations for staff dependent on their role. The practice also maintained records of staff receiving flu vaccinations. Those who had refused flu vaccines had signed declarations.

Appropriate and safe use of medicines

The practice had 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) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	1.12	0.91	0.87	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). (01/07/2018 to 30/06/2019) (NHSBSA)	8.4%	7.5%	8.6%	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 (01/01/2019 to 30/06/2019) (NHSBSA)	6.44	5.98	5.63	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	3.46	2.07	2.08	No statistical variation

Any additional evidence or comments
During our inspection in January 2019, we saw prescribing for antibacterial prescription items per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) was above average at 1.34 (01/10/2017 to 30/09/2018). The practice was aware of its higher than average antibacterial prescribing and was working towards improvement. It ascertained this in part to the high levels of socio-economic deprivation and historic prescribing practices. The practice was able to demonstrate it was working in collaboration with the CCG to drive improvement in this area. For example, through an audit of prescribing of high-risk antibiotic medicines. During this inspection, we saw there had been some improvement in this indicator and prescribing levels were no longer significantly above local and national averages. The practice was still working to reduce prescribing rates further, particularly for hypnotic medicines. The practice was undertaking focused reviews of medicines using the in-house clinical pharmacist. In addition, the practice was utilising additional mental health support services to provide holistic support to patients. For example, the use of an onsite MIND counsellor and a dedicated mental health nurse.

Track record on safety and lessons learned and improvements made

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:

During our inspection in January 2019, we reviewed the practice process for responding to safety alerts, including medicines and medical device alerts and found it needed improving. The alerts were received by the practice manager and disseminated to the clinicians for review and action. The practice could not demonstrate that a log of alerts and actions taken in response to them was maintained. We undertook a search of two recent safety alerts and found that whilst one had been actioned, the other (released in November 2018) had not been. On the day of inspection, the practice advised that they intended to take immediate action. Following our inspection, we were sent evidence to demonstrate a new system for managing safety alerts had been formulated. The practice advised all patients affected by the missed alert in November 2018 had been contacted and appointments booked where required (15 patients in total).

During this inspection, we noted significant improvements had been made to management of safety alerts. The practice's clinical pharmacist, practice manager and lead GP all received the alerts via email. The pharmacist was responsible for actioning alerts and sharing information with other clinicians as needed. In her absence, the lead GP and practice manager would action alerts. The pharmacist was able to demonstrate a clear process had been developed for handling alerts depending upon the nature of each individual alert. Actions were taken, and records were kept ensuring patient safety and to demonstrate compliance. We looked at examples of two recent alerts and saw they had been actioned as required. One alert was relating to increased risks from Hormone Replacement Therapy (HRT) in menopausal women. We saw that a search of patients affected by the alert was undertaken to identify those at risk. All of these patients were then reviewed to ensure risks to safety were minimised. Patients were informed of the alert and any associated impact on their treatment. All actions taken in response to alerts were recorded on a computer-based spreadsheet which was accessible to all staff.

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
- **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.