Care Quality Commission

Inspection Evidence Table

Sollershott Surgery (1-5683574043)

Inspection date: 03 March 2020

Date of data download: 06 March 2020

Overall rating: Good

At our previous inspection in July 2019, we rated the practice as requires improvement for providing safe services because:

- The practice's systems and processes to keep people safe were not always comprehensive.
- The practice's systems for the appropriate and safe use of medicines were insufficient.
- The practice did not have an effective system in place to ensure learning and action from significant events were always shared with relevant staff members.

Safe Rating: Good

The practice is rated as good for providing safe services because:

- The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.
- The practice had systems for the appropriate and safe use of medicines, including medicines optimisation.
- The practice learned and made improvements when things went wrong.

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

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y

Safeguarding	Y/N/Partial
Policies and procedures were monitored, reviewed and updated.	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
Staff who acted as chaperones were trained for their role.	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: At the time of our previous inspection in July 2019, not all staff members had completed safeguarding children training to the appropriate level for their role. Additionally, not all clinical staff had a DBS check in place and the practice did not have a policy in place to ensure all relevant staff members received a DBS check as part of their induction into the practice. During our inspection in March 2020, we found all staff members had completed safeguarding training and the practice had an effective system in place to ensure staff completed relevant training on a regular basis. The practice had reviewed their induction process and a DBS policy was in place. All staff members had received a DBS check.	

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 Public Health England (PHE) guidance if relevant to role.	Partial
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence: At the time of our previous inspection in July 2019, we found recruitment checks such as references were not always carried out. Not all staff members had received all of the required vaccinations for their role. During our inspection in March 2020, we found the practice had an effective system in place to ensure recruitment checks were carried out in accordance with regulations. The practice had the required vaccination records in place for all clinical staff members. The practice did not have sufficient vaccination records in place for all patient-facing non-clinical staff members. We saw evidence to confirm all non-clinical staff members had been reminded to provide a record of their vaccinations, a positive antibody test or evidence of a history of infection where this was permissible. A risk assessment was in place and staff members who were unable to obtain records from their GP practice had been offered the relevant vaccinations.	

Safety systems and records	Y/N/Partial

There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: February 2020	Y
There was a record of equipment calibration. Date of last calibration: 9 January 2020	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 20 February 2020	Y
There was a log of fire drills. Date of last drill: 3 February 2020	Y
There was a record of fire alarm checks. Date of last check: 28 February 2020	Y
There was a record of fire training for staff. Date of last training: 20 November 2019	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 21 November 2019	Y
Actions from fire risk assessment were identified and completed.	Y

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 3 February 2020	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 3 February 2020	Y
Explanation of any answers and additional evidence: At the time of our previous inspection in July 2019, we found the practice did not have evidence of portable appliance testing for all of the equipment. The practice did not have a health and safety and fire risk assessment. During our inspection in March 2020, we found the practice had comprehensive safety systems and records in place including health and safety and fire risk assessments.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 22 January 2020	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: At the time of our previous inspection in July 2019, we found the infection prevention and control policy was not accessible to all staff members and had not been kept up-to-date. The practice was unable to demonstrate how they acted on the recommendations following a Legionella risk assessment. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). During our inspection in March 2020, we found the practice had effective systems in place to ensure their infection prevention and control (IPC) policy was up-to-date and easily accessible to all staff members. All staff members had completed IPC training. An external contractor undertook a six-monthly Legionella risk assessment of the premises and water temperature checks were in place.	

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.	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
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented 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

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
Explanation of any answers and additional evidence: At the time of our previous inspection in July 2019, we found the practice did not always appropriately review and act on clinical documentation in a timely manner. During our inspection in March 2020, we found the practice had an effective system in place to ensure all clinical documentation was appropriately reviewed and acted on, when required, in a timely manner.	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation.

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 structured 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
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 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.	N/A
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

Medicines management	Y/N/Partial
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 PHE guidance to ensure they remained safe and effective.	Y
Explanation of any answers and additional evidence: At the time of our previous inspection in July 2019, we found the practice had not replaced an emergency medicine used to treat inflammation and pain, which had expired in May 2019. The practice had not completed a risk assessment to determine the range of emergency medicines held at the practice. A recommended emergency medicine used to treat heart failure was not available. The practice did not have a system in place to ensure clinical staff undertook a review of prescriptions that had been issued but not collected by patients. The practice did not have a documented process in place to manage uncollected prescriptions. During our inspection in March 2020, we found 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. The practice had a documented system in place for the monitoring and review of uncollected prescriptions and these prescriptions were reviewed on a monthly basis.	

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:	16
Number of events that required action:	16
Explanation of any answers and additional evidence: At the time of our previous inspection in July 2019, we found the practice did not have a significant events policy and was not able to demonstrate how learning and improvements from significant events was routinely shared with relevant staff members. During our inspection in March 2020, we found the practice had a significant events policy and this was accessible to all staff members. The practice had an effective system in place to ensure improvements from events and incidents were acted on and monitored and learning was shared with all relevant staff members.	

Well-led Rating: Good

At our previous inspection in July 2019, we rated the practice as requires improvement for providing well-led services because:

- The practice did not have clear responsibilities, roles and systems of accountability to support good governance and management in some cases.
- The practice did not have clear and effective processes for managing risks, issues and performance in some areas.

The practice is rated as good for providing well-led services because:

- There were clear responsibilities, roles and systems of accountability to support good governance and management.
- There were clear and effective processes for managing risks, issues and performance.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: At the time of our previous inspection in July 2019, we found clinical oversight and accountability within the practice had not been established across all areas. The governance framework in place to support the delivery of the strategy and oversight of processes was not effective in some areas. During our inspection in March 2020, we found the practice had taken adequate steps to address areas previously identified as requiring improvement. The practice had established clear responsibilities, roles and systems of accountability to support good governance and management. At the time of our previous inspection in July 2019, we found the practice did not always provide information about the Parliamentary and Health Service Ombudsman when sending a final response to patient complaints. (the PHSO make final decisions on complaints that have not been resolved by the NHS in England). From the sample of documents we viewed during our inspection in March 2020, we found the practice had a clear system in place to ensure information about the PHSO was provided as standard when responding to complaints.	

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y

Explanation of any answers and additional evidence: At the time of our previous inspection in July 2019, we found the practice did not have clear and effective processes for managing risks, issues and performance in some areas. Additionally, we told the provider that they should continue to take steps to ensure the patient monitoring and recall system was effective and continue to monitor patient feedback and survey results in relation to telephone access and appointment availability.

During our inspection in March 2020, we found the practice had taken adequate steps to address areas previously identified as requiring improvement. The practice had comprehensive assurance systems in place which were regularly reviewed. The practice had clear arrangements for identifying and managing risks and there was a programme of clinical audit to manage risks and monitor performance.

The practice had an improvement plan in place and monitored their performance across key areas. The practice had a comprehensive system in place to monitor and improve areas relating to the Quality Outcomes Framework (QOF). The practice had reviewed data from the National GP Patient Survey and had developed an action plan in response to this. The practice had reviewed and improved their appointment booking system and had increased the number of staff available to answer the telephone during busy periods. The practice worked closely with their Patient Participation Group (PPG) and the PPG had created an information leaflet for patients. The latest National GP Patient Survey results published in July 2019 showed the practice had improved across most indicators, including areas relating to telephone access and the overall experience of making an appointment, when compared with the survey results published in 2018.

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.