

# Care Quality Commission

## Inspection Evidence Table

### Parkbury House Surgery (1-575716460)

Inspection date: 23 November 2021

Date of data download: 02 November 2021

## Overall rating: Good

In February 2020, we rated the practice as requires improvement overall, with ratings of inadequate for providing safe services and requires improvement for providing effective and well-led services. These ratings were based on the following judgements:

- Staff did not always have the information they needed to deliver safe care and treatment. Not all pathology test results, including those older than one week, were clearly identified as reviewed and actioned or awaiting further action.
- The practice's systems for the appropriate and safe use of medicines, including medicines optimisation, were not always comprehensive. The process for monitoring patients' health in relation to the use of high-risk medicines with the appropriate monitoring and clinical review prior to prescribing was insufficient.
- The system for acting on safety alerts was not comprehensive.
- The practice's quality monitoring and improvement systems were not always effective at identifying and resolving issues, concerns, or below average performance.
- The practice did not always have effective governance structures, systems, and processes in place. This included those in relation to staff Disclosure and Barring Service (DBS) checks, staff vaccinations, staff training, fire safety systems, legionella management, the control of water temperatures, the monitoring of blank prescription stationery, the management of pathology test results, the monitoring and review of patients prescribed high-risk medicines, and the system for acting on safety alerts.

At this inspection,

- Improvements had been made to the management of test results and systems for monitoring of patients who were prescribed high-risk medicines.
- An improved protocol for the management of safety alerts had been effective in minimising risks.
- Developments to the practice's quality and improvement systems had been effective in identifying and resolving issues, concerns and below average performances.
- The practice had implemented new governance structures, systems and processes to reduce risk and provide assurance. These included the use of a digital portal and the assignment of individual responsibilities to specific areas to support effective governance.

The practice is rated as good overall.

# Safe

# Rating: Good

In February 2020 we rated the practice as inadequate for providing safe services because:

- Staff did not always have the information they needed to deliver safe care and treatment.
- The practice's systems for the appropriate and safe use of medicines, including medicines optimisation, were not always comprehensive.
- The system for acting on safety alerts was not comprehensive.

Following this inspection, the practice is rated as good for providing safe services because:

- Improvements had been made to the management of test results and systems for monitoring of patients who were prescribed high-risk medicines.
- An improved protocol for the management of safety alerts had been effective in minimising risks.

## 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
Explanation of any answers and additional evidence: At the previous inspection in February 2020 we found not all staff were trained to the appropriate level in regard to child safeguarding. During this inspection, we saw evidence to demonstrate all staff were trained to the appropriate level for their role. There was a dedicated member of staff responsible for maintaining oversight of staff training. We saw the practice used a digital platform to provide and monitor training for staff which was kept up to date.  In addition, we previously found gaps in the practice's system for determining which staff required a Disclosure and Barring Service (DBS) check. In particular, not all non-clinical staff undertaking chaperone duties had received a DBS check which conflicted with the practice's chaperoning policy. During this inspection, we saw evidence that all staff undertaking chaperone duties had received a DBS check.	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
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.	Y
<p>Explanation of any answers and additional evidence:</p> <p>During this inspection we saw that previously identified gaps in records maintained in relation to staff vaccination status had been filled. The practice had developed a role specific guide for required vaccines and were able to evidence a staff vaccination log which recorded staff immunity status.</p> <p>We reviewed five staff files during our inspection, and found records included information relevant to staffs employment were kept. Due to a changeover in the management team there were challenges in locating records for some staff members as documents were stored across multiple digital platforms, paper folders and computer files. The practice was aware of these challenges and staff were in the process of transferring all recruitment and staffing information to a digital portal. They envisaged this would support ease of reference once completed.</p>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 10/06/2021	Y
There was a fire procedure. Date of fire risk assessment: 15/01/2021	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>In February 2020, we found not all risks in relation to fire safety had been addressed as fire drills were not routinely undertaken at the branch site. During this inspection we were provided with assurances that identified risks had been removed in relation to fire safety. Fire drills were undertaken routinely every six months at both the branch and main site. In addition, a new smoke detector system had been installed at the branch site.</p>	

## **Infection prevention and control**

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

	<b>Y/N/Partial</b>
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:	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:

The practice regularly monitored water safety to ensure the risk of Legionella was minimised. Weekly checks on water temperatures were recorded in the practice's digital platform. In addition, water sampling checks were undertaken routinely by an external contractor to provide further assurance on safety.

## 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

Explanation of any answers and additional evidence:

Staff informed us there had been a significant turnover in both clinical and non-clinical staff in the months preceding our inspection. We saw that whilst some positions had been filled, there were ongoing efforts to recruit. Staff advised they worked well as a team to provide cover for staff absence, sickness and holidays but that there had been periods when they had felt under pressure and found it difficult to meet patient demand.

## 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
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:

At the previous inspection, in February 2020, we found there were a significant number of outstanding pathology test results awaiting action. During this inspection we saw systems had been improved to ensure all results were reviewed and actioned within a week. A buddy system had also been developed to ensure there was oversight during clinician absences.

## 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) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.64	0.68	0.69	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). (01/07/2020 to 30/06/2021) (NHSBSA)	9.5%	11.3%	10.0%	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 (01/01/2021 to 30/06/2021) (NHSBSA)	6.23	5.84	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	47.8‰	67.6‰	126.1‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	0.21	0.53	0.65	Variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	3.0‰	5.0‰	6.7‰	Variation (positive)

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

Medicines management	Y/N/Partial
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
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
<p>Explanation of any answers and additional evidence:</p> <p>During this inspection we saw the system for monitoring the use of blank prescription forms had been strengthened, this included the removal of all blank prescription forms from the branch site.</p> <p>In February 2020, we found systems for monitoring patients prescribed medicines that required routine monitoring needed improving. The practice took steps immediately after the inspection to offer assurance that risks to identified patients had been minimised.</p> <p>During this inspection we carried out a remote search of the practice clinical system and found that appropriate monitoring of patients prescribed high risk medicines was in place and appropriate medicine reviews had been completed. Patients were reviewed in a timely manner and there was evidence of patient recalls to remind patients to attend for monitoring appointments where necessary.</p>	

Medicines management	Y/N/Partial
Remote review appointments were made available as needed through the Covid 19 pandemic and repeat prescriptions were closely monitored. We noted that for some patients, blood pressure readings had not been taken within the specified timeframe. The practice advised there had been some delays with blood pressure readings through the course of the pandemic but they were undertaking a focused programme to encourage patients to submit blood pressure readings. All required blood tests for these patients had been completed.	

### Track record on safety and lessons learned and improvements made

### The practice learned and made improvements when things went wrong/did not have a system to learn and make 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 since January 2021:	Three
Number of events that required action:	Three
Explanation of any answers and additional evidence: Significant events were discussed at the clinical governance meeting where learning was identified and shared with staff. In addition to significant events, the practice maintained a log of identified learning. We saw there had been 12 learning events since January 2021.	

### Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Child immunisation error	A review of procedures was undertaken and staff were reminded of the importance of checking digital clinical notes and not to rely on the availability of the children's red book health record.
Cold chain breach	Following a fault with one of the fridges all vaccines were checked for safety in accordance with the practice policy and those that were unsuitable for use were disposed of.

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 February 2020, we identified concerns relating to the management of safety alerts including Medicines and Healthcare products Regulatory Agency (MHRA) alerts. During this inspection, we saw all alerts were now logged in the practice's digital platform which supported distribution of the alerts to relevant individuals. Individuals assigned to review the alerts through a digital portal had to record they had done so. Action taken in response to alerts was also recorded within the portal to ensure ease of access and follow up on actions if required. One individual was assigned responsibility for reviewing, actioning and disseminating alerts and they received administrative support with this role.



## Effective

## Rating: Good

In February 2020 we rated the practice as requires improvement for providing effective services because:

- The practice's quality monitoring and improvement systems were not always effective at identifying and resolving issues, concerns, or below averages performance.

At this inspection, we rated the practice as good for providing effective services because:

- Enhancements had been made to quality and improvement systems to ensure effective oversight and actions could be taken as required to improve safety and performance.

*QOF requirements were modified by NHS England for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.*

### Effective needs assessment, care and treatment

**Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y

## Effective care for the practice population

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. Individuals with multiple health conditions requiring a review could be reviewed in one appointment if needed.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

- Patients with asthma were offered an asthma management plan.
- We saw there were systems in place to identify and support patients who had been identified as at risk of developing diabetes.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	246	261	94.3%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	253	276	91.7%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	254	276	92.0%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	255	276	92.4%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	253	274	92.3%	Met 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

#### Any additional evidence or comments

The practice had established systems to support effective delivery of childhood immunisations. This included follow up for children who did not attend appointments for vaccinations and liaison with other health care providers if needed.

Cancer Indicators	Practice	CCG average	England average	England comparison
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). (Snapshot date: 31/03/2021) (Public Health England)	72.3%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	70.4%	69.1%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	70.4%	61.4%	63.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	55.3%	51.0%	54.2%	No statistical variation

#### Any additional evidence or comments

We spoke with practice staff about their efforts to achieve 80% attainment (the threshold set for the National Health Service Cervical Screening Programme to be effective). We found the practice operated a comprehensive reminder system for patients who did not attend for their cervical screening test. They demonstrated how they encouraged uptake of the screening programme, for example, by ensuring a female sample taker was available. Tests could be accessed at any time the nurses were working and not just in specified clinics. The practice advised they did not have a backlog of patients awaiting their cervical smear appointments following a brief pause to the programme during the Covid 19 pandemic.

## Monitoring care and treatment

**The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.**

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

The practice maintained a comprehensive programme of quality improvement activity which had continued throughout the Covid 19 pandemic. There had been 22 audits undertaken in the twelve months preceding our inspection. For example, the practice carried out a liver function monitoring audit in March 2021, for patients who were taking a specific medicine and had been diagnosed with cardiovascular disease.. The audit identified improvements could be made as only 50% of affected patients were receiving monitoring in line with recommendations. Improvements were made following the initial audit and a second audit in July 2021 showed 67% of patients were receiving appropriate monitoring. The practice aimed to continue monitoring and improvement in this area which would be assessed through auditing data as needed.

## Effective staffing

**The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.**

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: At our previous inspection in February 2020, we found some gaps in staff training, particularly in relation to safeguarding. However, during this inspection we found that all staff had received training appropriate to their roles.	

## Coordinating care and treatment

**Staff worked together and with other organisations to deliver effective care and treatment.**

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence: The practice held monthly meetings with the multi-disciplinary teams to discuss the care of patients with palliative or complex needs.	

## Helping patients to live healthier lives

### Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Patients had access to social prescribing services at the practice through a social prescriber employed by the primary care network (PCN). In addition, there was a team of 10 voluntary social prescribers (trained by Citizens Advice Bureau). These appointments were available through clinician referral and patient self-referral. The social prescribing volunteers had started a garden project at the Sandridge Surgery branch site in 2019, with both planning and financial backing from the local authority. This was designed as a therapy garden for anyone in the community to access.</p>	

## Consent to care and treatment

### The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Records we reviewed showed personalised advanced care planning was in place to record patient's wishes.</p> <p>The practice was following guidelines around Treatment Escalation Plans (TEPs), anticipatory care planning and Do Not Attempt CPR (DNACPR) orders.</p>	

## Well-led

## Rating: Good

In February 2020 we rated the practice as requires improvement for providing well-led services because:

- The practice did not always have effective governance structures, systems, and processes in place.

At this inspection, we rated the practice as good for providing well-led services as:

- Governance structures had been strengthened and there were clear responsibilities, roles and systems of accountability to support good governance and management.

### Leadership capacity and capability

**There was compassionate, inclusive and effective leadership at all levels.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: At the time of our inspection the practice had experienced significant challenges with changes to managerial, administrative and clinical staff. Whilst some vacancies had been filled there was still active recruitment underway to stabilise staffing levels fully. The leadership team held regular meetings to identify their current challenges and make succession plans. Staff feedback received was positive about the leadership team and support received from managers and colleagues throughout the Covid 19 pandemic and subsequent staffing shortages.	

### Vision and strategy

**The practice had a clear vision and credible strategy to provide high quality sustainable care.**

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y

### Culture

**The practice had a culture which drove high quality sustainable care.**

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y



Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff we spoke with were aware of the whistleblowing policy and reported they felt able to speak up. An internal Freedom to Speak Up Guardian was available and the practice were in discussions with their Primary Care Network (PCN) to appointment an external Freedom to Speak Up Guardian also.</p> <p>At our previous inspection, in February 2020, we found not all staff had received Equality and Diversity training. During this inspection, we saw Equality and Diversity training was a mandatory training module for all staff and all staff had completed training.</p>	

#### Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Staff feedback forms and interviews	Staff spoke positively about working at the practice, describing the practice culture as friendly, supportive and inclusive. Staff felt a sense of collective pride in their achievements throughout the Covid 19 pandemic, reflecting positively on their abilities to overcome challenges through collaborative working. Staff described the new management team as approachable.

#### 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
<p>Explanation of any answers and additional evidence:</p> <p>At the February 2020 inspection, we found there were multiple gaps in governance systems, for example relating to effective medicines management. During this inspection, we saw that governance structures had been strengthened. Recall processes were used to ensure patients received regular reviews in accordance with current guidance. Weekly clinical governance and monthly multi-disciplinary team meetings were in place to discuss the progress of patients. Test results were processed in a timely</p>	

manner and safety systems had been strengthened in relation to staff checks, prescription security and safety alert management.

### 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 quality improvement programme in place.	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

### The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>All staff had received a personal risk assessment and were able to work remotely if they needed to self-isolate.</p> <p>There was an increased use of telephone and video consultations during the Covid 19 pandemic. We were informed that patients were all offered an initial triage appointment via the telephone with a clinician to see if a face-to-face appointment was necessary.</p>	

Additional time was allocated for cleaning the surfaces of work areas after face to face appointments with patients.

Risk assessments of the building were made, and changes implemented to ensure the safety of patients and staff. For example, a one-way system was in place for patients and visitors to avoid congestion and hand gel was available at the entrance and throughout the building.

### Appropriate and accurate information

**There was a demonstrated commitment to using data and information proactively to drive and support decision making.**

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y

### Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y

### Engagement with patients, the public, staff and external partners

**The practice involved the public, staff and external partners to sustain high quality and sustainable care.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y

The practice had an active Patient Participation Group (PPG).	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<p>We saw there were various methods available for patients to express their views and leave feedback about their experiences including an online comments facility and an active Patient Participation Group (PPG).</p> <p>The practice had an effective system in place for handling complaints and concerns. Information was available to help patients understand the complaints system. Complaints notices were displayed around the practice and a leaflet detailing the complaints process was available. The full complaints procedure was available on the practice's website. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care or patient experience.</p> <p>The Patient Participation Group (PPG) met every three months and had continued to meet remotely through the course of the Covid 19 pandemic. There was a virtual PPG who were kept informed through emails communications. The social prescribing volunteers had started a garden project at the Sandridge Surgery branch site in 2019, with both planning and financial backing from the local authority. Designed as a therapy garden for anyone in the community to access, this already contained a hedge, fig trees and berry bushes. We were advised that works to the gardens had continued through the pandemic with produce distributed locally and ongoing plans to encourage community engagement with planting.</p>	

Feedback from Patient Participation Group.

### Feedback

We spoke with a member of the PPG who was able to provide examples of improvements undertaken following discussions between the PPG and the practice. For example, improvements to the practice website, telephone system and practice environment. We were informed the practice were open and transparent in their discussions with the PPG and actively sought feedback from the group.

### Continuous improvement and innovation

**There were systems and processes for learning, continuous improvement and innovation.**

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<p>There was a focus on teaching and training at the practice. The practice was a GP and nurse teaching, and GP training practice and maintained high standards for supporting its trainees and medical students. Five of the GPs were qualified GP trainers and one was an associate trainer. There were first and final year trainees at the practice through the West Herts training scheme and medical students from Cambridge University.</p>	

The practice demonstrated a positive approach to learning and improvement in response to the previous inspection in February 2020. We found required improvements had been discussed and implemented as a matter of priority. Newly developed systems had been embedded and routinely assessed for efficacy.

## 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 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.
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- $\%$  = per thousand.