Safe

Safety systems and processes

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

<table>
<thead>
<tr>
<th>Safeguarding</th>
<th>Y/N/Partial</th>
</tr>
</thead>
<tbody>
<tr>
<td>There was a lead member of staff for safeguarding processes and procedures.</td>
<td>Y</td>
</tr>
<tr>
<td>Safeguarding systems, processes and practices were developed, implemented and</td>
<td>Y</td>
</tr>
<tr>
<td>communicated to staff.</td>
<td></td>
</tr>
<tr>
<td>There were policies covering adult and child safeguarding which were accessible to all staff.</td>
<td>Y</td>
</tr>
<tr>
<td>Policies and procedures were monitored, reviewed and updated.</td>
<td>Partial</td>
</tr>
<tr>
<td>Partners and staff were trained to appropriate levels for their role.</td>
<td>Partial</td>
</tr>
</tbody>
</table>

Explanation of any answers and additional evidence:

At our inspection in March 2019 we found that:

- The practice’s safeguarding policy had not been updated to reflect current guidelines regarding the level of training required by staff.
- Not all staff were able to identify who the safeguarding lead was.
- Feedback from staff included that they did not know who to speak to regarding safeguarding concerns and if they needed to make a safeguarding referral, they would do so direct to the local authority.

At our inspection in June 2019 we found that:

- On inspection, the practice confirmed that the safeguarding lead was the registered nominated individual for the provider Cedar Medical Limited and that the safeguarding deputies were the practice manager and the clinical lead. During our inspection, we spoke to staff who corroborated this information and were able to identify who the safeguarding lead was and who they could go to, to report concerns. However, the practice’s safeguarding children policy had not been updated to reflect who the current safeguarding lead was. The policy identified two GPs who no longer worked at the practice as the safeguarding leads for the Rooksdown Practice and for the Beggarwood Surgery.
- On inspection we found that staff could access the safeguarding policies located on the shared
Safeguarding

- The practice’s safeguarding policies reflected current guidelines. For example, it was identified that all GPs and practice nurses should receive level three safeguarding children training. However, the practice was unable to evidence that all clinicians including locum staff had received up-to-date or had completed training in line with practice policy. For example, the practice’s training matrix identified that four clinicians had not completed safeguarding children level 3 training.

- The practice was unable to evidence that all non-clinical staff had received safeguarding training in line with practice policy. We reviewed the practice’s training matrix and found that eight members of staff had not completed safeguarding children training and nine members of staff had not completed safeguarding adults training.

Safety systems and records

- There was a record of fire extinguisher checks.
  Date of last check: Partial

- There was a log of fire drills.
  Date of last drill: Y
  Rooskdown Practice: 11 June 2019

- There was a record of fire alarm checks.
  Date of last check: Y
  Rooskdown Practice: 10 June 2019

- There was a record of fire training for staff.
  Date of last training: Partial

- There were fire marshals. Y

- Actions from fire risk assessment were identified and completed. Y

Explanation of any answers and additional evidence:

At our inspection in March 2019 we found that:

- No fire drill had been scheduled for the Rooksdon Practice in accordance with their fire risk assessment.
- Weekly fire alarm tests were not consistently conducted.
- The practice could not be assured that the fire extinguishers at the Rooksdon Practice would be effective if needed as they had not been serviced since May 2017.
- Staff had not received fire safety training and temporary staff including locums had not received a fire safety induction to the practice.

At our inspection in June 2019 we found that:

- A fire drill had been conducted at the Rooksdon Practice on 11 June 2019.
• Weekly fire alarm tests were being conducted consistently.
• While the fire extinguishers at the Rooksdown Practice had not yet been serviced, the practice provided evidence to show that this was raised with NHS property services who owned the building. The practice was waiting for a date to be confirmed for the checks to be conducted.
• We saw evidence that improvements had been made regarding staff fire safety training. We also reviewed evidence which showed all locum staff had confirmed that they had received a fire safety walk through in line with practice policy. However, the practice was unable to evidence that all locum staff had completed formal fire safety training.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

<table>
<thead>
<tr>
<th></th>
<th>Y/N/Partial</th>
</tr>
</thead>
<tbody>
<tr>
<td>There was an effective induction system for temporary staff tailored to their role.</td>
<td>Partial</td>
</tr>
<tr>
<td>When there were changes to services or staff the practice assessed and monitored the impact on safety.</td>
<td>Y</td>
</tr>
</tbody>
</table>

Explanation of any answers and additional evidence:

At our inspection in March 2019 we found that;
• There was not an effective induction for temporary staff tailored to their role.

At our inspection in June 2019 we found that;
• We saw evidence that the practice had implemented an induction check list for locums which included confirmation if they had received information about fire safety and if they had received a locum pack. This had been completed for all locum staff working at the practice, however they had not been signed by the clinician and the checklists had been backdated to when the clinician had started work at the practice rather than when the checklist had been completed. We discussed this with the practice management on inspection and they advised that this was an oversight.

Appropriate and safe use of medicines

The practice systems for the appropriate and safe use of medicines, including medicines optimisation were not yet embedded.

<table>
<thead>
<tr>
<th>Medicines management</th>
<th>Y/N/Partial</th>
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</thead>
<tbody>
<tr>
<td>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.</td>
<td>Partial</td>
</tr>
<tr>
<td>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.</td>
<td>Partial</td>
</tr>
<tr>
<td>There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.</td>
<td>Partial</td>
</tr>
<tr>
<td>Vaccines were appropriately stored, monitored and transported in line with PHE guidance</td>
<td>Partial</td>
</tr>
</tbody>
</table>
Medicines management

<table>
<thead>
<tr>
<th>Y/N/Partial</th>
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</table>

to ensure they remained safe and effective.

Explanation of any answers and additional evidence:

At our inspection in March 2019 we found that;

- The practice was not actively recalling patients for reviews of their medicines.
- The practice's process for the monitoring of medicine fridge temperatures and emergency medicines and equipment was not embedded.
- We found vaccines were stored in a manner which did not conform to guidance.
- The practice could not evidence that the medicine fridge at the Rooksdown Practice had been serviced.

At our inspection in June 2019 we found that;

The practice had made improvements in the monitoring of patients prescribed high-risk medicines. They had sent out a text invite to patients requesting they attend the practice for a review.

The practice had received support from an additional phlebotomist employed by the clinical commissioning group who had assisted in conducting blood tests and reviewing results.

We reviewed the progress made and found the following;

- For patients taking Lithium, six out of seven patients had received the appropriate monitoring and the remaining patient was due to attend the practice on the day of inspection for their review.
- For patients taking methotrexate, we identified 24 patients on this medicine. We reviewed the records of five of these patients and found that one was overdue the appropriate monitoring.

The practice advised that they had focused primarily of patients taking Lithium and Methotrexate. The practice could not be assured that patients taking other high-risk medicines had received appropriate monitoring. For example, we reviewed the records of patients taking Warfarin and found that of the six records we reviewed, one was no longer taking the medicine and three had not received appropriate monitoring.

We saw evidence that improvements had been made in relation to the storage of medicines, the recording of medicine fridge temperatures and the checking and recording of emergency medicines and equipment. However, processes were still not embedded and carried out consistently. We found the following;

- Medicine fridge temperatures were not consistently recorded daily for the morning and the afternoon in line with practice policy. For example, we reviewed the record sheet for June 2019 and saw that when we inspected on 12 June 2019, fridge temperatures at the Rooksdown Practice had not been recorded on one day and the afternoon temperature checks were not recorded on three days.
- Practice policy stated that if a USB data logger was used in the medicine fridges, this information should be downloaded on a weekly basis. However, the practice was unable to demonstrate that this had been done for the Rooksdown Practice or the Beggarwood branch for June 2019 (A data logger works by measuring an environmental parameter such as temperature using an internal thermistor or external thermocouple and sensors). We raised this with the practice who advised that the clinical commissioning group (CCG) had conducted those checks in the week before inspection, however the practice was unable to demonstrate this.
- Daily checks of emergency medicines and equipment were not consistent. When we inspected on 12 June 2019, we found that checks had not been conducted on two days in June 2019. The daily check list also did not accurately reflect the equipment held at the practice. For example, the check list showed that one oxygen cylinder had been checked, however we found that two oxygen cylinders were held at the practice. This was not reflected on the check list.
Medicines management

- The practice did not have a policy to ensure consistency across the two sites for the checking and recording or emergency medicines and equipment. At the Rooksdown practice, they used a tamper seal for the emergency medicines. They audited the emergency medicines once a month or if they saw that the tamper seal had been broken which would be picked up during the daily checks. This process was not maintained at the Beggarwood branch surgery. There was no tamper seal on the emergency medicines and staff were unclear about the process.
- We saw evidence that a service for the medicine fridge at the Rooksdown Practice had been scheduled for 26 June 2019.

**Effective**

**Effective needs assessment, care and treatment**

Patients’ needs were not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

| Patients’ immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Partial |
| **Patients’ treatment was regularly reviewed and updated.** | Partial |

Explanation of any answers and additional evidence:
At our inspection in March 2019, we found that there was no process to recall patients for reviews of their long-term conditions.

At our inspection in June 2019 we found that since the practice’s clinical lead had been in post, the practice had begun to recall patients for their health reviews. They advised that they had run searches with a focus on patients diagnosed with diabetes or who were identified as being pre-diabetic. They had also looked at improving the coding of patients prescribed medicines.

We reviewed the progress they had made and found the following:
- On 14 May 2019 the practice conducted a search and identified that no patients diagnosed with diabetes had received a complete health review covering all 8 required clinical areas since 1 April 2019.
- On 11 June 2019 the practice ran a duplicate search and found that following the implementation of their process, 9% of patients diagnosed with diabetes had now received an appropriate health review.

**Caring**

**Privacy and dignity**
The practice did not always respect patients’ privacy and dignity.

| Curtains were provided in consulting rooms to maintain patients’ privacy and dignity during examinations, investigations and treatments. | Y |
| Consultation and treatment room doors were closed during consultations. | N |

Explanation of any answers and additional evidence:

At our inspection in March 2019 we found that the practice’s process to ensure patients’ privacy and dignity was respected, was not embedded.

At our inspection in June 2019 we found that the practice had made improvements but that the learning was not yet embedded.

- On inspection, we saw that a consulting room door was left open during a consultation and a member of the inspection team was able to observe the patient from where they stood.
- Privacy and dignity training had been assigned to staff, but this had not been completed.

Well-led

Governance arrangements

There were not always clear responsibilities, roles and systems of accountability to support good governance and management.

| There were governance structures and systems which were regularly reviewed. | Partial |
| Staff were clear about their roles and responsibilities. | Partial |

Explanation of any answers and additional evidence:

At our inspection in March 2019 we found:

- Governance processes did not ensure all staff were appropriately trained.
- The practice did not have a system to ensure all policies were up to date and embedded.
- Staff were not always clear about their roles and responsibilities.

At our inspection in June 2019 we found that governance arrangements had improved but not all processes were embedded.

- Improvements had been made in relation to the completion of fire safety and safeguarding training. However, we saw evidence that this had not yet been completed by all practice staff.
- Practice policies had been updated to reflect current guidelines. For example, the safeguarding policy stated that GPs and nurses should complete level 3 safeguarding children training in line with current guidelines. However, the safeguarding policy stated that two GPs who no longer worked at the practice were the safeguarding leads for the Rooksdown Practice and the Beggarwood branch.
- No policy had been implemented to give structure to how checks for emergency medicines and equipment should be conducted. We found that there were inconsistencies in how these checks were conducted across both sites and staff were unsure which process was appropriate.
- Improvements had been made in relation to the recording of medicine fridge temperature checks but they were still not embedded.
Managing risks, issues and performance

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

<table>
<thead>
<tr>
<th></th>
<th>Y/N/Partial</th>
</tr>
</thead>
<tbody>
<tr>
<td>There were comprehensive assurance systems which were regularly reviewed and improved.</td>
<td>Y</td>
</tr>
<tr>
<td>There were effective arrangements for identifying, managing and mitigating risks.</td>
<td>Y</td>
</tr>
</tbody>
</table>

Explanation of any answers and additional evidence:
At our inspection in March 2019 we found that the practice’s fire safety processes were not embedded.

At our inspection in June 2019 we found the practice had improved their fire safety processes. However, we saw that processes to ensure locum staff received and understood practice safety information was not always clear. For example, the induction checklists for temporary staff had not been signed by the member of staff or practice management. It had also been backdated to the date the clinician had started at the practice instead of the date they had received the information.

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.

<table>
<thead>
<tr>
<th></th>
<th>Y/N/Partial</th>
</tr>
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<tbody>
<tr>
<td>Staff views were reflected in the planning and delivery of services.</td>
<td>Y</td>
</tr>
</tbody>
</table>

Explanation of any answers and additional evidence:
At our inspection in March 2019 we found that communication between managers and staff was limited and they did not hold staff meetings.

At our inspection in June 2019 we found that arrangements had been put in place for regular meetings at the Rooksdonw Practice and the Beggarwood branch. Weekly clinical meetings were held at both sites which was used as an opportunity to share learning. The practice had also implemented a reception team meeting which they advised would be held every two weeks.
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:

<table>
<thead>
<tr>
<th>Variation Bands</th>
<th>Z-score threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant variation (positive)</td>
<td>≤-3</td>
</tr>
<tr>
<td>Variation (positive)</td>
<td>&gt;-3 and ≤-2</td>
</tr>
<tr>
<td>Tending towards variation (positive)</td>
<td>&gt;-2 and ≤-1.5</td>
</tr>
<tr>
<td>No statistical variation</td>
<td>&lt;1.5 and &gt;1.5</td>
</tr>
<tr>
<td>Tending towards variation (negative)</td>
<td>≥1.5 and &lt;2</td>
</tr>
<tr>
<td>Variation (negative)</td>
<td>≥2 and &lt;3</td>
</tr>
<tr>
<td>Significant variation (negative)</td>
<td>≥3</td>
</tr>
</tbody>
</table>

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.
- 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.

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

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.