CQC Findings
Huntingdon Road Responses

1. We saw that portable appliance testing (PAT) was not carried out by a qualified person to ensure electrical equipment was safe to use. The provider told us that visual checks were completed by practice staff. However, no documentation was provided in support of this or to demonstrate staff had the competency for this role. Following the inspection, the practice informed us PAT had been booked for January 2020.

The "Walkaround" process at the Practice is structured in such a way to allow us to identify risks which may have been overlooked.
The Walkaround involves the review of each area against site-specific Infection Prevention and Control standards, as well as the routine inspection of cleanliness, site and equipment maintenance, electrical items and equipment, health and safety risks and fire risks. The Walkaround happens regularly across all areas on our premises at both sites, including outside areas.
On the day of the inspection we notified the inspector that, in line with the Health & Safety guidance for a low risk environment, the practice operates a system under which a competent member of staff undertakes visual inspections.
We have documentary evidence that visual inspections of the electrical equipment are made as part of the Walkaround. The forms for the Walkaround have a section for inspection of equipment. We provided this evidence at the wrap-up discussion (and at the inspector's request later emailed it to him) however it has been omitted from the report.
In addition, we carry out weekly fire alarm checks plus monthly emergency lighting tests during which visual inspection of portable appliances is carried out. All medical equipment is calibrated on an annual basis, which provides a further opportunity for visual inspection. All staff are aware and do proactively raise any concerns with regard to building maintenance and electrical equipment with the Operations Manager.

2. We found that fire and health and safety risk assessments were generic and lacking in detail specific to the practice premises. This did not provide assurance that all potential risks had been identified by the provider.

At first glance, and if read in isolation, the "Fire Risk Assessment" may appear to be generic as it is intended to cover generic risks across the whole of both our premises. However the document does also consider location specific risks particular to our practice and buildings. For example, the section on fans notes that most are operated under direct supervision of the occupant but that two fans are in public areas not under direct supervision. Moreover, this document forms only part of a comprehensive series of Risk Assessments, which although presented on the day of inspection, were overlooked in the report.

Risks are generally anticipated by a change in processes, staff, buildings or equipment. Typically they will be identified during the Practice Monday Meeting.

The "Walkaround" process is structured in such a way to allow us to identify risks which may have been overlooked.
The Walkaround involves the review of each area against site-specific Infection Prevention and Control standards, as well as the routine inspection of cleanliness, site and equipment maintenance, electrical items and equipment, health and safety risks and fire risks.

The Walkaround happens regularly across all areas on our premises at both sites, including outside areas.

The result is that we develop separate location and risk-specific Risk Assessments, which are far more specific and detailed than one overriding document.

Examples of these include:

- Office - Risk Assessment
- Asbestos
- Legionella
- Lone Working
- Snow and Ice
- Girton Dispensary Risk assessment
- Girton IPC at Girton Surgery
- Clinical Rooms – use of couches
- Clinical Rooms – use of oxygen cylinders
- Use of ConMed Hyfrecator
- Cryosurgery/Liquid Nitrogen

Each of these is detailed, specific to location, and highlights what action we have taken to mitigate against those risks. For example: the RA on Asbestos details the exact location of asbestos risks in our premises and specifics about how these rises are managed; the RA on IPC risks at Girton is specific and detailed; the RA on Legionella is location specific and detailed, and reviewed at each quarterly IPC meeting, as evidenced in the IPC minutes we provided and which are available online.

Individual Fire Risks are also covered in our Waste Management Policy and in our Monday Meetings. Neither of which are referenced in this section of the report. For example, the Walkabout process highlighted a potential concern over the housing of the practice wheelchair to avoid obstructing fire exists. This was discussed in our Monday Meeting and a decision was made to house it in a location which minimises risk whilst allowing the wheelchair to be readily available. This discussion and action is documented in our Monday Meeting minutes.

Furthermore, on the day of inspection we presented evidence of our mechanisms for keeping these risk assessments up to date, including our "Index (Log) of Risk Assessments" (see attached) which again appears to have been overlooked in the report.

All the risk assessments were up to date on the day of the inspection. We do not understand why the report states that our "health and safety risk assessment" was updated in March 2016.

<u>When considered together</u> our processes for identifying risks and the set of risk assessments form a comprehensive risk-specific and location-specific risk management process. We feel that the inspection team failed to ascertain our systems for risk management as they seemed to have a fixed idea as to how these should be managed.

3. The practice provided examples of infection prevention and control audits. However, these audits did not cover the entire practice premises and the most recent audits in several areas were last undertaken in 2016.

> There may have been some confusion over nomenclature here over what was meant by "infection prevention and control audits".
>
> Our understanding was that we were being asked to provide evidence that we audit our systems with regard to infection prevention and control (IPC) issues.

To that end, on the day of the inspection we provided numerous examples of audits (what we term "Infection Prevention and Control Audits") which we have undertaken, some into their 3rd audit cycle. Examples include:

- Audit on infections post minor surgery
- Audit on infections post ear syringing
- Audit on the prescribing of sharps bins (to minimise risks of inoculation injury to patients and staff)

These audits are available online and are referred to in our IPC minutes and IPC reports. They appear to have been completely overlooked in the report.

At interview, Dr Hayton, our Infection Prevention and Control Lead, did also present the IPC team's review of our waiting room which was carried out in April 2016. This is cited in the report. However there is no reference to the fact that after that date we changed our process for reviewing the premises, by introduction of the practice Walkaround.

The Walkaround involves the review of each area against site-specific Infection Prevention and Control standards, as well as the routine inspection of cleanliness, site and equipment maintenance, electrical items and equipment, health and safety risks and fire risks. The Walkaround happens regularly across all areas on our premises at both sites, including outside areas. The Walkabout is carried out with our Infection Prevention and Control Lead using standards set in conjunction with input from the CCG IPC Lead Nurse (Lyn Rodrigues). Indeed, Lyn has joined us for the Walkabout in the past.

If we had known that the inspectors were specifically looking for evidence that we *review* our *premises* for infection prevention and control issues, we would have presented the information regarding our Walkabout process.

This misunderstanding was discussed at the wrap-up discussion on the day of the inspection. Our lead inspector acknowledged that the structured Walkabout was the process by which we review the practice premises and reassured us that the Walkabout would be included and considered in this section of the report. At his invitation, we then forwarded him evidence of the Walkabout, the most recent round being in August 2019.

However the draft report still cites the single waiting room "audit" performed in 2016. This misrepresents our processes and disregards the clarification and explanation which we provided at the wrap-up meeting.

Were you to contact Lyn Rodrigues you would find that we are in frequent communication with her, and have worked in partnership with her on all our buildings upgrades, IPC policies and processes and on IPC training. She and her colleague Belinda Sadler (now retired) have often commended us for our IPC systems and our engagement with them and have used us as exemplars of good practice. We are very proud that our premises at the Huntingdon Road site are of such high standard (which is not mentioned in the report) and are confident in our IPC processes, which were commended in our last inspection and which have been expanded upon in the meantime.

4. The practice did not provide evidence infection prevention and control risks at the branch site had been identified, considered and mitigated.

We are aware of several potential IPC risks at the Girton branch site. These were discussed with the inspector who interviewed our IPC Lead (Dr Hayton) and our Nurse Manager at the Girton site on the day of the inspection.

We presented the risk assessment on IPC risks at Girton (attached) which identifies, considers and action taken to mitigate against these risks. We gave the inspector a copy of the document.

We also presented our imminent plans to upgrade the Girton site to bring it up to IPC standards and to improve patient confidentiality, explaining that renovation work is due to commence there this month. Dr Hayton showed the inspector the design plans which are on display on site for patient involvement.

This information has quite simply been completely omitted from the report.

The statement that the practice had not acted on issues identified in infection prevention and control audits is factually incorrect. Previously, the Walkaround highlighted substandard décor in the staff waiting room and in a few doctors clinical rooms at the Huntingdon Road site. These have subsequently been upgraded. Likewise the Walkaround highlighted IPC issues at the Girton site. The renovation work is commencing soon, and in the meantime effective risk management is in place.

5. The practice did not provide evidence clinical staff had complete oversight of relevant blood test results prior to prescribing warfarin. Following the inspection, the practice told us a new system had been implemented to ensure warfarin was only prescribed following receipt of a relevant blood test result.

We acknowledge the CQC feedback concerning warfarin prescribing.
Our local anticoagulation service was set-up approximately 15 years ago. It was commissioned knowingly without the facility for GPs practices to be copied into or be able to download INR results. This was deemed a safe service at the time in Cambridge. We are informed by the anticoagulation laboratory when patients fail to submit INR specimens on the advised date. The laboratory writes to the patient and GP if they are not following the monitoring guidelines.
Huntingdon Road Surgery has continued to sign up for the anticoagulation LES annually and provide blood taking and prescribing services for our warfarin patients. Our systems and the anticoagulation service have not changed since our CQC inspection in 2016 when we were rated 'Outstanding'.

Our phlebotomists and nurses routinely check the INR information received from the anticoagulation service and record this in the patients' records prior to taking blood. Although most of our warfarin patients come to the surgery there are several whom have their blood taken by other community services whom are not part of our organisation and may not have access to our records to record relevant INR information.
Our individual list system and detailed knowledge of our patients has enhanced our ability to provide safe care. The INR results are recorded in the patients' records by our phlebotomists and can be reviewed by the doctor at the time of prescribing warfarin.
Since the CQC inspection we have contacted the head of the anti-coagulation service to ask for access to INR information for our patients.

We received this response:
'Unfortunately the software we use does not allow us to relay this information to you electronically. We do also routinely write to the patient and GP if they are not following our monitoring guidelines'

We are aware of other CCGs including East and North Herts Trust and PAH in Harlow whereby GPs have easy access to downloadable INR information. We have reviewed other Cambridge GP Surgery CQC reports and recognise that there was prior knowledge of the institutional issues as other practices have 'Requires Improvement' status in their Safe domain for warfarin prescribing.

We have raised our concerns with the Lead of the Cambridgeshire and Peterborough Prescribing Team and the LMC as we believe the current CGG commissioned service needs to be safer for all practices across the area. Both parties are currently liaising with the CCG on our behalf to review the safety of the anticoagulation service and to consider what effective changes can be made.

Within the practice since the inspection we are ensuring that all INR information is coded on our records using the anticoagulation template when patients are seen in the surgery. We have also changed our prescribing protocols and now have listed warfarin as a doctor only medication issue. This ensures a further safety check of the INR information is made prior to issuing warfarin.

6. We found that the system for monitoring prescription stationery was not effective at the branch site

All prescription paper is logged on arrival at the main Huntingdon Road site and when any is issued to an area of the practice. Records clearly identify script numbers and the location of the prescription stationery.
The Girton site only receives prescription stationery from the Huntingdon Road Site. Prescription paper is issued from Huntingdon Road to Girton only in whole, unopened boxes. The box number is logged in the folder at the Huntingdon Road Surgery, and since the prescription paper numbers are recorded for each box, our process allows us to identify which prescriptions are sent to Girton.
At the Girton site, the prescriptions paper is kept locked safely in the dispensary. The paper is used exclusively in the dispensary and in the single GP room adjacent to the dispensary. The site at Girton is tiny, and prescriptions are only held in one of two places. That means that at any time we are able to tell which prescriptions are in which room.

Prescriptions in either location are in any case locked securely (throughout our premises all our prescription printer trays are locked at all times) but if someone did somehow steal a prescription from the doctor's room, our system would allow us to know which serial numbers they were.
Likewise at any time we are able to identify the location of stationery with any given serial number.
The inspectors seemed only to be looking for evidence that we were signing prescription stationery in a particular way.
Since the inspection, and at the suggestion of the inspectors, we created an additional log form for Girton branch surgery. This logs the receipt of prescription stationery on site, and which pages are issued to the doctors consulting room. This system was implemented on 5 December 2019. We welcome this amendment to our process but the reality is that this does not seem to add any additional protection to the recorded stationery.

7. We found the practice had a higher Quality Outcomes Framework exception reporting rate for all long-term condition indicators; some of which were significantly higher than the Clinical Commissioning Group (CCG) and England averages. The practice were aware of this data; however, there were no plans to reduce the number of exceptions made.

The practice is aware of our higher than average QOF exception reporting. Unfortunately, it appears that we have not been able to convey the measures we have taken and the continuing work we are carrying out to reduce the number of exceptions. As explained on the day of the inspection, we go above and beyond the mandated GMS contracted measures of trying to contact patients before we consider exception reporting them. New contract rules state that a patient may be exception reported after two invites for review. Despite these changes, we have continued to use three invitations in for patients plus additional phone call communication. Our individual list system means that we have detailed knowledge of our patients' context and preferences. This allows us to direct our invitations to achieve the greatest possible response. We have a robust recall system in place run by our admin team to ensure patients are contacted at regular intervals until they attend. Our nurse manager monitors availability of appointments to ensure adequate provision of chronic disease appointments as recorded in the minutes from the Monday practice meetings.

We understand that patients respond to a variety of media and therefore we use a combination of postal letters, text messages, telephone calls and opportunistic invites to contact patients. Our Operations Manager demonstrated the way we contact patients on the day of the inspection.

Towards the end of the QOF year the Operations Manager sends the registered GP a list of patients who have not attended for review. As we run personal lists we feel the registered GP may have an insight as to how to persuade the patient to attend for a review.

These existing and constantly developing measures demonstrate the practice's commitment to reducing the exception reporting rate at Huntingdon Road Surgery. We continue to develop innovative new approaches including recent Patient Group meetings regarding chronic diseases. These meetings are held in the evening and are attended by the practice management, medical and nursing teams. We understand that the inspection team was made aware of the ongoing programme of meetings by the Patient Group representatives on the day of the inspection.

8. The practice's cervical screening uptake was significantly lower than the 80% Public Health England target rate at 54.4%.

We acknowledge that our achievement of cervical screens is below the national target, but we continuously and proactively benchmark our performance against our local practices, those locally within the "Cambridge Association of Student Practices" (https://www.cambridgeshireandpeterboroughccg.nhs.uk/your-health-and-services/cam-student-health/association-of-student-practices-in-cambridge/) **and** reference areas elsewhere in the country with reportedly similar populations such as Oxfordshire. We have also compared our rates to those of another university city (Southampton).
Included below are figures taken from the most up-to-date achievement rates *(1)*, and in particular attention is drawn to the following:
Within the cities of Cambridge and Oxford, and the University of Southampton practice, achievements for cervical screening was comparable, and universally short of the national 80% achievement target. Indeed the practices within the cities of Cambridge and Oxford all achieved <70% cervical screen achievements, and the University of Southampton practice achieved 55%
Within the Cambridge Association of Student Practices, the range of cervical screen achievement varies from 47% to 62%. Interestingly, the achievement of cervical screens for every single one of these practices is significantly higher in the more stable 50-64 year age group (variation between 65.5% to 76.7%; Huntingdon Road scoring 76.7% in the older age group).
We have been aware that this issue is not limited to Cambridge, Oxford or Southampton: our membership of the National Association of Student Practices saw this very issue being raised, with similar negative criticism at a CQC inspection, of another practice in the East of England.
Analysing our eligible women who have not attended for screening, the impact of students is very significant. 11% are students from one college for mature female students alone. This is despite the involvement of a practice team at the time of student registration and contact with the student welfare officers and tutors.
Huntingdon Road Surgery complies fully with the requirements of the NHS Cervical screening call and recall programme, and indeed goes "above and beyond" the specifications therein, by particularly raising the profile of cervical screening to the attention of eligible women.

Measures by which this has been done include:

1. The use of pink paper for the third cervical screen invitation letter
2. At the expense of the practice a large pink sign has been produced and fixed to the front of the surgery, with the words "Don't fear the smear, it could save your life" printed on it. This has resulted in many positive comments from women, stating it reminded them to attend for their cervical screen, AND helped start conversations with teenagers, bringing the importance of attending for screening into discussions and helping to "normalise" the expectations of attending for screening.
3. Every appropriate opportunity is taken to extend personal invitations to eligible women. In particular during appointments. We audited this particular activity for a single GP, on the day of our CQC inspection, and found that of the eligible women who had not attended for cervical screens 50% had been reminded of this, or had an appropriate discussion about the importance of attending cervical screening, in the preceding 12 months for that GP alone.

4. With our newly forged links with the University Welfare Officers, alongside meeting the College Nurses and Tutors of an all-female mature student college, we have raised the importance of attending for cervical screens to those who can help encourage the students to attend for cervical screens

These additional efforts, despite being brought to the attention of the inspectors, were minimised, and some not even acknowledged in the draft report.
We feel there is a lack of attention to our particular population demographics and appropriate benchmarking with other practices of similar demographics, instead comparing us to a national standard with a lack of recognition of the efforts being made. Many of our recent innovations have not yet born results as there has been insufficient time to have seen an impact on achievement rates.

Despite these additional efforts to increase cervical screen uptake by the practice, our numbers of cervical screen achievements remain below the 80% national average. However we are absolutely in-line with our peer student practices, both locally within Cambridge, as well as comparing ourselves to Oxford and Southampton as just two examples. NHS England's Service Specification Number 25, for Cervical Screening, *(2)* outlines the responsibility of NHS England to optimise coverage and uptake across their catchment area and co-operate with regular analysis of coverage to identify groups of women who either access screening at lower levels, or do not access services at all.

We would argue that the known national falling trend in cervical screens achieved, as well as the lower achievements for those practices who have significant numbers of eligible post-graduate students, raises the question about this being a much wider issue for NHS England as a whole, and begins to raise questions about the point and time at which NHS England needs to review the process as a whole, rather than point out the lack of engagement across the country with the NHS cervical screening programme.

(1) From data taken from:
https://digital.nhs.uk/data-and-information/publications/statistical/cervical-screening-programme/cervical-screening-programme-coverage-statistics-management-information
The practice has been aware of the difficulties of achieving cervical screening targets through our links with the National Association of Student Practices, where in October 2018 another practice in East Anglia outlined their difficulties trying to engage with students, particularly those from overseas who access healthcare systems when back home in their countries, do not engage with NHS cervical screening. This echoed the experience of Bristol practices 3-5 years prior to that.

9. Not all staff had received an appraisal in the last 12 months. We found that three members of staff had not received an appraisal since June 2018 and ten appraisals scheduled for October 2019 had not taken place at the time of inspection

As explained on the day of the inspection, we introduced a more comprehensive appraisal form in 2019 for employees to complete, to include SMART objectives with purpose and deadlines.

The report should be corrected to read: Members of staff who previously had their appraisals in June 2018, had their 2019 appraisals completed in September 2019 in accordance with the adjusted timetable agreed with all staff.

All appraisals were scheduled in during an 8 week period, in October/November to consolidate the workload. All staff completed their appraisal documentation, and 360 feedback was compiled during September.

The appraisals that were due in October/November 2019 and had been booked in the appropriate management diaries. These appraisals were postponed due to highly exceptional circumstances These factors were stated on the day of the inspection.

The exceptional circumstances to which we referred were; that the line manager underwent abdominal surgery at short notice, and was subsequently signed off work for a fortnight. Immediately after her return, the Admin Partner Lead was forced to take compassionate leave, to deal with Palliative Care requirements of a parent.

The appraisals were therefore re-scheduled for a time when both members of the management team were available to host the meetings – December/early January.
All staff were made aware, and were offered the opportunity for an earlier date with a different Partner/Manager. All staff preferred to wait until their line manager and lead GP were available as they value continuity.

All appraisals have now been completed. See attached details.
Every member of staff has had an annual appraisal for the last 5 years.
We have included the previous 2 years data in the attached table.

10. Review and improve systems for monitoring patients in the secondary waiting area.

Further to the most recent Walkaround on 11th November, we discussed whether the telephone/notice alerting patients if any concerns/emergencies, was sufficient. It was agreed that there was a potential risk, should there be only one person in the waiting room that may fall ill/need urgent assistance - as it could be up to 10 minutes before a Doctor went to collect the patient for their consultation. Our Receptionists advise patients if a Doctor is running late (as long as the patient has checked in at the front desk or at the checking in machine).

It was agreed at the Practice meeting on 25th November (see note from minutes below) that we would purchase and install a CCTV camera, so that reception (front desk) can 'view' and monitor the upstairs waiting room and the stairs leading to it, at all times.

The camera was purchased and delivered, and the installation booked for Tuesday 3rd December, however this was delayed due to logistical and technical issues. This was discussed on the day of the inspection, and the inspectors had sight of the CCTV.

The upstairs waiting room risk was discussed at the Monday business meetings (see minutes excerpt from one of the meetings below) and was discussed verbally and in email correspondence between the partners, practice manager and business manager. A formal risk assessment document had not been produced as the minutes had recorded discussions. A risk assessment was sent to The Lead Inspector following the inspection, with the understanding that it would be included as evidence to support this finding and detailed in the draft report, however this did not happen.

The CCTV is now operational and a notice has been put in place advising patients of the monitoring for safety purposes.

Business Meeting Minutes Part 1 25th November 2019.

Other Items · CCTV in upstairs waiting room ALL	25/11/19 Re-discussed having camera in upstairs waiting room at HRS.	Agreed to install camera in upstairs waiting room with monitor located in reception downstairs. A sign to inform pts about the rationale for this camera will be placed in the upstairs waiting room i.e to identify unwell patients/cases of emergency.