

Care Quality Commission

Inspection Evidence Table

Aspen Medical Practice (1-1482438584)

Inspection date: 16 December 2020

Date of data download: 08 January 2021

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Partial
Explanation of any answers and additional evidence: <p>The practice had a system for processing information relating to new patients. However, interviews with staff indicated that the practice did not conduct quality assurance checks on work completed by experienced summarisers. (A medical summariser summarises all medical notes and letters. This provides healthcare professionals with an accurate, easily accessible electronic summary of a patient's medical history) We were told when staff first trained to summarise patient notes, they received checks on their work to ensure accuracy however they were not aware that this process had continued beyond their initial training. This meant the practice could not be assured of continued accuracy. Following inspection, the practice told us that they were looking at purchasing correspondence management training for summarisers. They also planned to appoint a clinical partner to support quality assurance processes in the summarising team.</p> <p>The practice's care home protocol did not give sufficient guidance to staff on what information should be shared between services for new registered patients. A GP we spoke with advised that a discussion should be held with the care home and the lead GP for the service to discuss medical requirements for new patients to ensure safe patient care. However, this process was not included in the practice's policy and feedback we received prior to inspection indicated that this was not always carried out. We were told that the practice had introduced advanced care planning which involved input from the care home staff, the patient, their family and other agencies involved in the patient's care. This process included the completion of a RESPECT form and a discussion regarding the desire for cardiopulmonary resuscitation (CPR) in an emergency. (The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices.) This process had been introduced for new patients and would be rolled out gradually for existing patients.</p>	

Following inspection, the practice sent us evidence that they had updated their protocol for care home management to ensure new patients were registered with necessary information from the care home. The practice advised that all new patients who were residents in a care home facility, should have a registration form completed by the care home. Previously, this process was not always completed. The policy update included that patients would only be registered if a care home registration form was completed.

Effective

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
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients' treatment was regularly reviewed and updated.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Following concerns we received regarding the care and treatment of a patient diagnosed with Dementia and Diabetes, we reviewed 64 records of patients diagnosed with these conditions and identified that their care and treatment had been managed appropriately. However, our inspection indicated that the practice did not have a policy on exception reporting to give guidance to staff and did not have a formal system to review patients who had been exception reported. (Exception reporting allows practices to exclude eligible patients from indicators or an entire clinical domain of the Quality and Outcomes Framework.) We were told that patients received two invites for their annual health review and if they failed to engage with the practice following the second invite, the practice's clinical system automatically exception reported those patients. We were told that patients who were exception reported were identified opportunistically and would then be referred to the appropriate practice department for further engagement. Following inspection, the practice sent us evidence that they had introduced an exception reporting policy. The policy detailed patients who may be exception reported and how some patients could receive opportunistic monitoring.</p>	

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	57.8%	68.3%	66.9%	No statistical variation
PCA rate (number of PCAs).	15.3% (292.0)	18.8%	15.3%	N/A

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	94.0%	85.9%	81.4%	Variation (positive)
PCA rate (number of PCAs).	3.8% (11)	8.5%	8.0%	N/A

Well-led

Governance arrangements

There were not always 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.	Partial
There were appropriate governance arrangements with third parties.	Partial
Explanation of any answers and additional evidence: We reviewed a selection of practice protocols including the protocol for Diabetes and the summarisation of new patient notes. Both protocols had been regularly reviewed. However, some practice policies did not contain all necessary information, for example the policy on care home management. The practice also did not always have policies to give operational guidance to staff. For example, a specific policy on exception reporting. Therefore, the practice could not be assured that all staff followed the same processes. Following inspection, the practice sent us evidence that they had updated and introduced necessary protocols.	

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)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > 1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **PHE:** Public Health England.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)).
- **%** = per thousand.