

# Care Quality Commission

## Inspection Evidence Table

### Fusehill Medical Practice (1-9586218623)

Inspection date: 18 June 2021

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

## Safe

### Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Policies and procedures were monitored, reviewed and updated.	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 inspection in October 2020 we saw that policies and procedures for safeguarding were in place, but these were not regularly kept up to date and were not being followed. The safeguarding register had not been audited and updated in the past 18 months, meaning patients who may have been put on safeguarding plans during that time would not be showing on the practice's system. We also saw from the medical records that children on the safeguarding register were not being reviewed and that conversations with other professionals were either not taking place or were not being recorded.  At the follow-up inspection in June 2021 we saw that the safeguarding register had been reviewed and updated and that discussions had taken place with the local "Strengthening Families" team to ensure everyone who should be included on the register was on there. A safeguarding lead and deputy lead were in post and people were able to tell us who they were and how they would raise concerns with them. We saw minutes of meetings which were now taking place with other professionals to discuss children on the safeguarding register.	

### Risks to patients

**Gaps in systems to assess, monitor and manage risks to patient safety had been addressed.**

	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At the inspection in October 2020 we found that higher-than-average use of temporary GPs combined with a lack of lead roles meant there was reduced clinical oversight at the practice. In June 2021 we saw that the provider had appointed a full-time, permanent GP who would act as clinical lead at the practice and be present at the practice each day. While the practice still primarily used non-permanent clinical staff we saw there were plans in place to try and recruit GPs to permanent contracts. Other new staff, such as reception staff, had been hired since the last inspection to help manage the workload at the practice.</li> <li>In October 2020 we saw that none of the signature sheets at the back of the locum induction pack had been signed to confirm this had been completed. We were told the practice did not keep these forms once they had been signed by the locum staff but they would do so in future. In June 2021 we saw this was now the case.</li> </ul>	

## Information to deliver safe care and treatment

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

	Y/N/Partial
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>In October 2020 we saw there were systems in place to monitor referrals, discharge letters, and test results, however we were told there was no formally designated lead person for each of these systems, meaning there was no continued oversight to ensure they were carried out regularly and promptly. We saw that this resulted in there being no follow up when things were missed, or that actions were being marked as completed when they had not been. For example, we saw mental health reviews which had been coded as having been completed when the records showed the patient had not attended.</p> <p>At the most recent inspection in June 2021 we saw that the practice had appointed a clinical director who was on site at the practice daily. Along with the practice manager, they had responsibility for overseeing the assignment tasks to staff each week, including nominating staff to manage referrals, discharge letters, and test results. This was checked daily by the clinical director, practice manager, and reception manager to ensure these tasks had been completed correctly. A GP specialist advisor reviewed the practice's clinical system to check that there were no outstanding referrals, discharge</p>	

letters, and test results and found that they were all up-to-date.

### Appropriate and safe use of medicines

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

Medicines management	Y/N/Partial
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

Explanation of any answers and additional evidence:

- In October 2020 we saw that processes for the safe handling of requests for repeat medicines and structured medicines reviews for patients were in place, but we were told that designated lead roles had not been established to ensure these were always carried out correctly, promptly, and regularly. As such the systems relied on staff checking them when they thought to do so. In June 2021 we found that systems were now in place to ensure that requests for repeat medicines were being actioned and structured medicines reviews for patients were taking place. The practice was receiving support with this from the medicines optimisation team at the local clinical commissioning group (CCG).
- At the first inspection in October 2020 we saw that medication reviews were out of date, with searches for patients on certain high risk drugs which required three-monthly blood tests having not been run in the last six months. At the follow-up inspection in June 2021 we found that the practice was still trying to increase the number of medication reviews carried out, with 47% of all patients on a repeat medication and 52% of patients who were regularly prescribed four medications or more having had a review. The practice shared with us their plans to increase this number to 85% of all patients over the next four months. We spoke to the CCG who confirmed the practice had been working with them to improve. A GP specialist advisor reviewed the practice's EMIS system as part of this inspection and found that the practice had focused on ensuring patients who were prescribed high risk medicines were reviewed as a priority.

# Well-led

## Governance arrangements

**There were responsibilities, roles and systems of accountability to support 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
Explanation of any answers and additional evidence:	
<p>In October 2020 we saw that governance structures and systems were in place but there were gaps in these which could potentially lead to risks. In June 2021 we saw that action had been taken to address these gaps. For example:</p> <ul style="list-style-type: none"><li>• In October 2020, formally designated lead roles had not been established for the safe handling of requests for repeat medicines and structured medicines reviews. As such, we saw that searches for patients on certain high risk drugs which required three-monthly blood tests having not been run in the last six months. In June 2021 we found that there was now a system in place for assigning these roles and for monitoring that tasks had been completed. The practice was receiving support from the medicines optimisation team at the local clinical commissioning group to carry out medication reviews and there was a plan in place to increase the number of reviews carried out;</li><li>• In October 2020 there was no formally designated lead person to monitor referrals, discharge letters, and test results, to ensure these were regularly checked and actioned. In June 2021 we saw that staff were appointed to these roles each week and that the clinical director, practice manager, and reception manager were checking to ensure tasks were being completed. We performed a search of the practice's EMIS system and found that referrals, discharge letters, and test results were being actioned in a timely manner;</li><li>• In October 2020 the provider carried out a workflow audit to ensure that tasks such as checking test results or referrals had not been missed, but this was run on a six-monthly basis which meant that results or referrals may have been overdue by the time they were discovered. Checks were taking place weekly when we re-inspected the practice in June 2021;</li><li>• In October 2020 there was a higher-than-average use of temporary GPs, and a lack of clinical oversight at the practice. This in turn meant the oversight of the locum staff was not as robust as it should have been. In June 2021 we saw that a GP had been appointed as clinical director to work at the practice in Carlisle and provide clinical oversight. They were on site daily and had put a number of systems in place to address the concerns we had raised at the last inspection. They had also been given a role at board level for the provider to improve the link between practice-level management and the leadership team at the provider. This GP also did two clinical sessions alongside their management work, meaning they were seeing patients, reducing the need to use locums and potentially improving continuity of care. While the practice continued to use temporary GPs we saw that steps had been taken to recruit more permanent members of staff, and GPs who worked for the provider's other practices were able to offer remote appointments on a more long-term basis.</li></ul>	

## Managing risks, issues and performance

### There were processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>In October 2020 the safeguarding register had not been audited and updated in the past 18 months, meaning patients who may have been put on safeguarding plans during that time would not be showing on the practice's system. In June 2021 we saw that the register had been audited and updated and meetings had taken place with other professionals to ensure the register was correct.</li></ul>	

## 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.