

# Care Quality Commission

## Inspection Evidence Table

### Giffard Drive Surgery (1-549743288)

Inspection date: 29 July 2021

Date of data download: 29 July 2021

## Overall rating: Good

At our previous inspection on 10 October 2019, we rated the practice Good overall. However, we rated Well Led as Requires Improvement and we rated population group children and young people as Requires Improvement. During this desk top review we looked only at the areas identified as requiring improvement. The previous ratings for Safe, Effective, Caring and Responsive remain unchanged.

We found that the practice had made the required improvements to governance and recruitment systems, as detailed below and we were therefore able to improve the rating of Well Led from Requires Improvement to Good.

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

## Effective

## Rating: Good

The rating for this key question overall has not changed since our last inspection in October 2019.

During this desk top review we improved the rating for population group Families, children and young people from Requires Improvement to Good because the data demonstrated that the practice was now meeting the appropriate targets.

### Families, children and young people

### Population group rating: Good

#### Findings

- At our last inspection on 10 October 2019 we found the practice had not met the minimum 90% target for three of the four childhood immunization uptake indicators.
- At this desktop review we found the practice has met the minimum 90% for all five childhood immunisation uptake indicators. The practice has also met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for one of five childhood immunisation uptake indicators.

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)	142	149	95.3%	Met 95% WHO based target
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)	89	94	94.7%	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)	89	94	94.7%	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)	89	94	94.7%	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) <small>(NHS England)</small>	116	123	94.3%	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>

## Well-led

## Rating: Good

At our last inspection on 10 October 2019, we rated Well Led as requires improvement because there were some governance arrangements which required review and some risks that had not been identified by the practice to ensure appropriate improvements were made.

At this desk top review we found the practice had fully addressed the areas which required improvement. We found that consent processes had been audited, Disclosure and Barring (DBS) risk assessments were in place, there were different systems in place to share patient records with authorised third parties (such as the GP out of hours service), there was a new process in place to monitor and track histology results and there were new systems and new staff recruited to ensure high risk medicines were not represcribed without appropriate blood tests.

This meant we were able to improve the rating from Requires Improvement to Good.

### 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
Explanation of any answers and additional evidence: At our last inspection on 10 October 2019 we found there were some governance concerns highlighted to the practice, which were unknown to the leadership team. For example there was no monitoring of the consent seeking process for minor surgery to ensure that consent was sought in line with guidance. During this desk top review we found the practice, following national guidance, had ceased carrying out minor surgical procedures during the COVID-19 pandemic. The practice had restarted delivering minor procedures and used a new patient record template to record which included an embedded consent form. This helped to ensure consent was recorded for all patients. We also reviewed the outcome of two consent audits which demonstrated the consent process had been correctly recorded for all patients who had attended the practice for a minor procedure.	

### 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
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: At our last inspection on 10 October 2019, we found there were some areas where the governance arrangements required oversight or monitoring. For example, we found that a DBS risk assessment had not been carried out for a member of staff who had started work before the result of the DBS check was known to the practice. We found some patient group directions (PGDs) required review as some	

signature dates meant they had not been appropriately authorised. A PGD is a generic prescription enabling nurses to administer medicines and vaccines without an individual prescription. We also found that a monitoring log for emergency medicines had not identified that one medicine had passed its expiry date. In addition, the practice did not routinely share care plans with third party providers, such as the out of hours GP service or the ambulance service.

During this desktop review, we found there was a process to risk assess staff if they needed to start work prior to receiving the results of their DBS check. The practice told us this happened more often with administrative staff as they often started work with little notice. We were told that administrative staff received four to six weeks training at the start of their employment meaning they did not work unaccompanied for the first few weeks. The DBS was usually received by the time they started to work alone. We reviewed the DBS risk assessment form as part of this desk top review.

During this desktop review, we reviewed five PGD forms selected at random and found these had been appropriately dated and authorised. The practice told us they were in process of transferring the paper PGD process into digital form, which would allow easier monitoring.

We also reviewed the emergency medicines monitoring log for the previous five weeks and did not find any discrepancies. Once the log was complete, the practice did not retain copies and therefore we were unable to check previous records. The practice noted that retention of these records would provide more assurance around the process for ensuring emergency medicines and equipment were in date.

The practice told us that local providers all used the same clinical system and they use a shared care record. This includes the integrated care team, the community team, paramedics and the hospice team. GPs could see what was written into the patients' records by other healthcare professional and vice versa, which helped create a joined up approach for the patient. This had been a local development since the last inspection.

## 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 effective arrangements for identifying, managing and mitigating risks.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection on 10 October 2019 we found there was no process for ensuring histology (tissue sample) results for minor surgery were received and reviewed, there was no process to ensure that information about patients who had failed to collect their prescription was taken into account at their next medicine review. We also found repeat prescribing records for some high risk medicines did not include details of the most recent blood test result.</p> <p>At this desk top review the practice told us they maintained a histology book which recorded all procedures where a sample had been taken for examination in a laboratory. Laboratory test results</p>	

usually took six weeks to process and practice staff chased results which had not been received within eight weeks. We reviewed a photocopy of the book as part of this review.

The repeat prescribing system had completely changed since our last inspection and the practice had implemented a fully electronic prescribing system. This meant prescriptions were sent directly to local pharmacies and patients no longer needed to attend the practice to collect their prescription. The practice told us that other documents which needed to be collected by patients, such as Xray forms, were monitored by administrative staff and if there were any concerns identified, the patient's GP was made aware.

Since the last inspection the practice had recruited a pharmacy technician and a full time clinical pharmacist. Prescribing policies had also been overhauled and we reviewed these as part of this desk top review. We found these policies to be appropriate. The clinical pharmacist maintained oversight of the high risk medicines re-prescribing system and three monthly monitoring had been set up to coincide with patients' medicines review dates. We were told that most patients prescribed high risk medicines were under shared care arrangements and therefore most blood tests were carried out at the practice. A few, such as those for rheumatology patients, were carried out at the hospital by the secondary care team, and the practice was able to access the hospital system to view blood test results. We reviewed the results of three searches identifying, by patient record number, patients who had been prescribed specific high risk medicines. The results showed that all patients prescribed those medicines had received appropriate blood test monitoring.

## 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.
- \*PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
- 
- $\text{‰}$  = per thousand.