

Care Quality Commission

Inspection Evidence Table

Fitzalan Medical Group (1-559739083)

Inspection date: 21 November 2018

Date of data download: 20 November 2018

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Safe

Rating: Inadequate

Risks to patients

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

| Question | Y/N |
|---|-----|
| There was an effective approach to managing staff absences and busy periods. | Yes |
| Comprehensive risk assessments were carried out for patients. | Yes |
| Risk management plans were developed in line with national guidance. | Yes |
| Explanation of any answers: | |
| <p>We saw evidence that the practice had conducted a proper assessment of outstanding long-term condition reviews and had a realistic plan to conduct outstanding reviews.</p> <p>The practice identified a lack of annual review appointments for patients with long-term conditions. We saw evidence that the practice had taken steps to address this:</p> <ul style="list-style-type: none">• The practice had employed a new nurse, qualified to conduct long-term condition reviews.• The practice had reviewed and redesigned rotas to effectively provide appointments for long-term condition reviews.• The practice had established rules for staff booking leave. This meant that rotas could be planned and appointments booked further in advance.• The practice had introduced annual review prioritisation policy for scheduling annual reviews for patients with long term conditions. <p>We saw evidence that the practice was monitoring performance on a weekly and monthly basis, which has demonstrated an improvement in the number of long-term condition reviews that had been carried out. The practice had predicted the number of reviews required each week against the number of available appointments and we saw evidence this data was being used to plan rotas.</p> | |

Information to deliver safe care and treatment

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

| Question | Y/N |
|---|-----|
| The practice had a documented approach to the management of correspondence and this was managed in a timely manner. | Yes |
| <p>Explanation of any answers:</p> <p>We saw that the practice had updated their policies to include contingency plans and revised timescales for correspondence handling.</p> <p>We saw minutes of meeting, dated 11 October 2018, where the changes were discussed.</p> <p>An additional member of staff was being trained to code correspondence and had been in post four weeks. When we spoke with them they described the internal training they had received and told us about an external clinical coding course they had attended.</p> <p>A further member of staff, who was experienced in clinical coding, has been employed to provide an additional days coding until January 2018.</p> <p>We reviewed the current correspondence within the document handling system and found that there was no correspondence in the system that was older than one working day and the majority had been received on the day of inspection.</p> <p>There were 147 items in total, of which 144 had been received on the day of inspection and three from the previous day.</p> <p>We saw documented records demonstrating the practice was monitoring the volume of outstanding correspondence daily. This demonstrated that the backlog was cleared on 13 November 2018 and since then there has only been one item of correspondence that took longer than one working day to resolve.</p> | |

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

| Medicines Management | Y/N |
|--|-----|
| There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. | Yes |
| The practice monitored the prescribing of controlled drugs. (For example, audits for unusual prescribing, quantities, dose, formulations and strength). | Yes |
| <p>Explanation of any answers:</p> <p>We saw evidence that the practice had updated the its repeat prescription and medication review protocol to include the monitoring process.</p> <p>Templates had been made available within the clinical computer system for all prescribers, which provided pop up alerts when blood tests were overdue. It also provided the appropriate monitoring criteria and thresholds. When the templates were correctly completed they coded the information into the clinical system. The practice demonstrated they were using this information to audit performance.</p> <p>We saw copies of meeting minutes where changes were discussed. GPs we spoke with told us that they had received refresher training in the use of the clinical templates and the updated policy.</p> <p>The prescribing lead had responsibility for reviewing and sharing the monthly progress report to all GPs.</p> <p>We saw evidence of two main audits;</p> <ol style="list-style-type: none">1. Patients on high dose opioids2. Patient requesting opioids regularly <p>Medication reviews</p> <p>The practice had assessed the number of medication reviews that needed to be completed before the end of the year and planned the number that needed to be completed each month. We saw evidence that the practice was auditing progress monthly.</p> <p>The prescribing lead had carried out quality audits of ten medication reviews from each prescriber. We saw the results were shared with prescribers on 6 November 2018. A repeat audit was planned for January 2019.</p> <p>We saw meeting minutes, dated 1 November 2018, where changes were discussed. The prescribing lead had provided medication review refresher training to all prescribers and standard templates were made available within the clinical system to ensure consistency.</p> <p>In October 2018 the practice had completed 97% of their target medication reviews, and by 14 November 2018 they had completed 99%.</p> | |

Effective

Rating: Inadequate

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.

Any additional evidence

We saw evidence that the practice had carried out a proper assessment where figures indicated exception reporting was high. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.)

The practice had made the following changes to its call and recall protocol, which included the exception reporting process. This came into effect on 9 November 2018;

- a lead clinician for exception reporting was confirmed.
- exceptions must be authorised by a clinician.
- a clinical risk assessment must be carried out and recorded by a clinician before a patient is exception reported.
- children are not exception reported.

We saw meeting minutes where these changes were discussed and all staff made aware. We also saw evidence of a monthly audit that demonstrated progress was being monitored.

People with long-term conditions

| Diabetes Indicators | | | | |
|---|--|--------------------|------------------------|---------------------------------|
| Indicator | Practice performance | CCG average | England average | England comparison |
| The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF) | 86.9% | 83.7% | 78.8% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 29.3% (314) | 17.8% | 13.2% | |
| Indicator | Practice performance | CCG average | England average | England comparison |
| The percentage of patients with diabetes, on the register, in whom the last blood pressure | 67.9% | 77.4% | 77.7% | Comparable with other practices |

| | | | | |
|---|---|---------------------------|-------------------------------|--|
| reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF) | | | | |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 15.2% (163) | 16.1% | 9.8% | |

| Indicator | Practice performance | CCG average | England average | England comparison |
|---|---|---------------------------|-------------------------------|---------------------------------|
| The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF) | 77.8% | 80.1% | 80.1% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 22.6% (242) | 22.0% | 13.5% | |

| Other long term conditions | | | | |
|--|---|---------------------------|-------------------------------|---------------------------------|
| Indicator | Practice | CCG average | England average | England comparison |
| The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF) | 78.1% | 68.8% | 76.0% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 29.4% (340) | 15.2% | 7.7% | |
| Indicator | Practice | CCG average | England average | England comparison |
| The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF) | 93.7% | 81.9% | 89.7% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 20.2% (96) | 15.8% | 11.5% | |

| Indicator | Practice | CCG average | England average | England comparison |
|---|--|--------------------|------------------------|---------------------------------|
| The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF) | 82.0% | 78.8% | 82.6% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 13.8% (326) | 6.2% | 4.2% | |
| Indicator | Practice | CCG average | England average | England comparison |
| In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF) | 86.4% | 87.8% | 90.0% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 6.4% (19) | 6.8% | 6.7% | |

Families, children and young people

| Child Immunisation | | | | |
|--|-----------|-------------|------------|--------------------------------|
| Indicator | Numerator | Denominator | Practice % | Comparison to WHO target |
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018)(NHS England) | 201 | 219 | 91.8% | Met 90% minimum (no variation) |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England) | 197 | 217 | 90.8% | Met 90% minimum (no variation) |
| 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) (01/04/2017 to 31/03/2018) (NHS England) | 200 | 217 | 92.2% | Met 90% minimum (no variation) |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to | 200 | 217 | 92.2% | Met 90% minimum (no variation) |

| | | | | |
|---------------------------|--|--|--|--|
| 31/03/2018) (NHS England) | | | | |
|---------------------------|--|--|--|--|

Working age people (including those recently retired and students)

| Cancer Indicators | | | | |
|--|----------|-------------|-----------------|---------------------------------|
| Indicator | Practice | CCG average | England average | England comparison |
| 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) (01/04/2016 to 31/03/2017) (Public Health England) | 66.5% | 74.0% | 72.1% | Comparable with other practices |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE) | 67.5% | 72.2% | 70.3% | N/A |
| Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE) | 50.2% | 61.2% | 54.6% | N/A |
| The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (PHE) | 55.3% | 66.0% | 71.3% | N/A |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2016 to 31/03/2017) (PHE) | 55.7% | 52.1% | 51.6% | Comparable with other practices |

People experiencing poor mental health (including people with dementia)

| Mental Health Indicators | | | | |
|--|--|--------------------|------------------------|---------------------------------|
| Indicator | Practice | CCG average | England average | England comparison |
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF) | 67.3% | 74.7% | 89.5% | Variation (negative) |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 42.7% (82) | 22.4% | 12.7% | |
| Indicator | Practice | CCG average | England average | England comparison |
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF) | 80.8% | 79.8% | 90.0% | Comparable with other practices |

| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
|---|--|--------------------|------------------------|---------------------------------|
| | 32.3% (62) | 17.4% | 10.5% | |
| Indicator | 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 (01/04/2017 to 31/03/2018) (QOF) | 69.5% | 82.6% | 83.0% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 26.0% (46) | 9.2% | 6.6% | |

Monitoring care and treatment

| Indicator | Practice | CCG average | England average |
|---|----------|-------------|-----------------|
| Overall QOF score (out of maximum 559) | 535.6 | - | 537.5 |
| Overall QOF exception reporting (all domains) | 11.4% | 7.3% | 5.8% |

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 comparable, 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 comparable 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 Band | Z-score threshold |
|---|----------------------------------|-------------------|
| 1 | Significant variation (positive) | $Z \leq -3$ |
| 2 | Variation (positive) | $-3 < Z \leq -2$ |
| 3 | Comparable to other practices | $-2 < Z < 2$ |
| 4 | Variation (negative) | $2 \leq Z < 3$ |
| 5 | Significant variation (negative) | $Z \geq 3$ |
| 6 | No data | Null |

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.

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: <http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework (see <https://qof.digital.nhs.uk/>).
- **RCP:** Royal College of Physicians.
- **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. ([See NHS Choices for more details](#)).