

# Care Quality Commission

## Inspection Evidence Table

**Dr Christopher John George Wright (1-506336798)**

Inspection date: 28 June 2019

Date of data download: 04 July 2019

## Overall rating: Unrated

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

**Safe**

**Rating: Unrated**

**The practice had improved 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 <sub>1</sub>
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Y
Explanation of any answers and additional evidence: 1. At the last inspection we found that four staff were not clear about who acted as the practice safeguarding lead. There were several safeguarding policies within the practice and there was no reference to the practice safeguarding lead in the policies we reviewed. Staff at the practice could not confirm if all staff had completed child and adult safeguarding training.  At this inspection, we found that safeguarding policies were updated to include the name of the safeguarding lead and contact details of local services. The staff we spoke with knew who the safeguarding was and had received safeguarding training.	

Recruitment systems	Y/N/Partial
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y <sub>1</sub>
Explanation of any answers and additional evidence:	

1. At the inspection in February 2019, the practice did not have a system in place to monitor the professional registrations for clinical staff employed at the service and to ensure registrations were up to date. Staff told us that they knew the professional registration of the lead GP was valid as they had paid their annual retention fee. Staff could not confirm that the practice nurse or the locum GP employed at the service were currently registered with their relevant professional bodies.

At this inspection, we found that the practice had copies of all relevant staff's registration certificates and had created a diary entry with renewal dates.

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met/not met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y <sub>1</sub>
Explanation of any answers and additional evidence:	
<p>1. Staff spoken to during the inspection in February 2019, were unclear on who acted as the infection control lead. The practice nurse could not confirm that they had completed infection control training in the last 12 months and they told us that their responsibilities around infection control had not been clearly outlined. There was a lack of oversight of staff infection control training. The infection control lead was not designated in the practice policy and the CCG infection control lead named in the policy was not correct.</p> <p>At this inspection, the practice's infection control policy had been updated to detail the infection control leads in the practice, outlined their responsibilities and provided the contact details for the CCG infection control lead. All staff had undertaken infection control training.</p>	

## 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 to monitor delays in referrals.	Y <sub>1</sub>
Explanation of any answers and additional evidence:	
<p>1. At the last inspection, staff informed us that there was no failsafe system in place to monitor two-week wait referrals.</p> <p>At this inspection, we found that the practice had created a colour-coded spreadsheet listing referrals and outlining whether a patient's appointment had been confirmed and completed. There were two folders with the titles, 'done and seen' and 'pending' the latter was checked weekly. Patients that had an outstanding appointment were highlighted in red.</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/Partial
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y <sub>1</sub>
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y <sub>2</sub>
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y <sub>3</sub>

Explanation of any answers and additional evidence:

- At the last inspection, the practice did not have effective systems in place to securely store and monitor the usage of prescriptions. We saw that boxes and pads of printer and controlled drug prescriptions were stored in a locked room. However, this room would have been accessible to contract cleaning staff. Staff confirmed that printer prescriptions were not locked away at the end of each day. Although the rooms were lockable they were accessible to contract cleaning staff. We saw that there was a log of controlled drug prescriptions used but there was no log of the number of boxes of printer prescriptions.

At this inspection the practice had created a prescription log, listing prescription numbers and the number of boxes of printer prescriptions. Prescriptions (including those in the GPs' printers) were placed in a locked cabinet within a locked room. The cabinet key was locked in a key cabinet which was only accessible by practice staff.
- At the last inspection, we searched the clinical systems for patients prescribed azathioprine. There were six patients prescribed this medicine. Four of these patients were having regular monitoring. Two of these patients had not been having regular medication monitoring completed. We also reviewed 11 patients who were prescribed methotrexate and found that one patient who had not had any monitoring completed since 21 May 2018.

At this inspection, we found that all patients prescribed azathioprine had received a medication review. We also found that all patients prescribed methotrexate had received a medication review.
- At the last inspection, we reviewed the practice's supply of emergency medicines and found that there was no GTN spray held or Glucagon or Glucagel.

At this inspection, we found that the practice had both GTN spray and Glucagon in stock.

### Track record on safety and lessons learned and improvements made

### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Y

There was a system for recording and acting on significant events.	Y <sub>1</sub>
Explanation of any answers and additional evidence: 1. Three staff spoken to at the inspection on February 2019 did not know what constituted a significant event. At this inspection we spoke to three members of staff all of whom were aware of the criteria for significant events.	

# Effective

# Rating: Unrated

## Effective needs assessment, care and treatment

**In the main, patients' needs were assessed, and care and treatment was delivered in line with current legislation. However, there were areas where the practice required improvement.**

	Y/N/Partial	
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial <sub>1</sub>	
Explanation of answer and additional evidence: <ul style="list-style-type: none"><li>At the last inspection, a patient was last issued medication on 5 February 2019 for two months. Their last blood monitoring was completed on 15 May 2018 in secondary care. There were "medication review" entries in the patient's clinical notes on 5 February 2019 and 4 July 2019 but no details of the review completed or anything additional to indicate a review had been completed. At this inspection, we found that the practice continued to log medication reviews as completed but had not listed any detail of what had been discussed or reviewed during the consultations. We discussed this with the provider and was told that this was due to time constraints between appointments.</li><li>At the inspection in February 2019, we found that a patient's last blood monitoring was completed on 22 August 2018 in secondary care. A two-month supply of medication had been issued to the patient on the following dates: 1 November 2018, 7 December 2018 and 14 January 2019. From reviewing the records of these patients and other patients who had received regular blood monitoring and from discussions with staff, we found that there was a lack of formal processes for reviewing patients prescribed high-risk medicines and that there were no shared care agreements in place for the patients who were being monitored in secondary care. After the inspection, the practice responded that blood monitoring tests were done in February 2019 and gave normal results and a home visit had been carried out in March 2019 when the patient condition was reviewed. At this inspection, the practice had Shared Care Agreements in place, for patients who were monitored in secondary care. They had also developed a protocol for monitoring disease modifying anti-rheumatic drugs. We reviewed the practice's prescribing and found that patients had received the appropriate checks prior to prescriptions being issued.</li><li>The practice's low QOF performance for dementia patients was raised at the last inspection in February 2019. At this inspection, six out of the eight dementia patients had not received a care plan within the last 12 months.</li><li>At this inspection, we discovered that two patients test results had not been communicated.</li></ul>		

## Effective staffing

**The practice was able to demonstrate that clinical staff had the skills, knowledge and experience to carry out their roles.**

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y <sub>1</sub>
Explanation of answer and additional evidence: 1. At the last inspection, there was no system in place to oversee staff training. We reviewed five staff and found that all staff had completed basic life support training; although one of these staff members had not completed this within the last 12 months. Staff spoken to on inspection were not able to confirm that these staff members had completed safeguarding, infection control, information governance and fire safety training. we were provided with details of staff training after our inspection. At this inspection, staff had completed all the mandatory training subjects for their roles.	

## Well-led

**Rating: Unrated**

### Leadership capacity and capability

**There was compassionate, inclusive and effective leadership at all levels.**

	Y/N/Partial
There was a leadership development programme, including a succession plan.	Y <sub>1</sub>
Explanation of answer and additional evidence: 1. During the inspection in February 2019, staff confirmed that there were no firm succession plans in place if the lead GP retired or decided to leave. At this inspection, we were told that the practice had not created a succession plan because the provider did not have any plans to leave or retire from the practice and would give a year's notice if circumstances changed. The provider felt that the practice's incorporation in to the Primary Care Network (groups of practices working with other health and care organisations, contributing to integrated care systems) in July 2019, meant that the need for succession planning was effectively redundant. The practice was also in talks regarding merging with another practice which was a member of the Primary Care Network.	

### 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 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.
- 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.

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>

#### 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.