Care Quality Commission

Inspection Evidence Table

Avisford Medical Group (1-562962584)

Inspection date: 20 September 2019

Well-led

Rating: Requires improvement

The practice was previously rated as requires improvement for providing well led services. This was because whilst there was evidence of systems and processes for learning, continuous improvement and innovation, learning from significant events and complaints was not always used or shared effectively to make improvements

At this inspection, we found that the practice had made some improvements to the way it shared learning from significant events and complaints. However, we found that the practice had not fully implemented its action plan and still required improvement because:

- The practice policy for reporting significant events did not make clear what constituted a significant event or how they should be prioritised.

- The practice did not maintain an accurate or complete chronological log or central summary of significant events to enable it to monitor action and identify trends.

- The practice had not fully implemented the new significant event reporting form, referred to in its action plan. Clear actions and the person responsible were not always recorded or brought back to subsequent meetings to be closed.

- There was limited evidence to show whether enough information gathering or investigations in to the root cause had taken place. This meant appropriate action and lessons learned were not always identified.

- Complaints were not always responded to within the timescales set out in the practice complaints policy and response times were not monitored.

- The practice did not maintain a clear audit trail or accurate log of complaints. Records were kept in different places and were sometimes difficult to find.

- Records of complaints were brief and there was limited evidence to show whether sufficient investigations had taken place.

- Learning that was identified from complaints was not always widely shared. We saw that a culture of openness and transparency was not embedded.

- The practice had not implemented a system for assuring that all safety alerts received were disseminated appropriately and acted on.

Culture

The practice culture did not always effectively support high quality sustainable care.

	Y/N/Partial
The practice encouraged candour, openness and honesty.	Partial
Explanation of any answers and additional evidence: It was not always clear from the practice records how and whether lessons from complaints were shared. Discussions with the practice manager and the registered manager confirmed that lessons learned from complaints were sometimes only discussed with the individual staff member concerned and not shared with the wider team. This meant that staff were not always encouraged to be open and transparent about mistakes or to share learning with the wider team to prevent re-occurrence.	

Managing risks, issues and performance

The practice did not always have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were effective arrangements for identifying, managing and mitigating risks.	N

Explanation of any answers and additional evidence:

Whilst the practice had a policy in place for identifying and managing significant events, it did not make it clear what constituted a significant event or how they should be prioritised. It was therefore not clear how risks would be identified.

We saw that whilst staff had filled in significant event forms, the new form identified in the practice's action plan was not being used consistently. Forms were often incomplete and did not always identify clear outcomes or actions and the person responsible for implementation. There was no evidence from any of the significant event records, including meeting notes, that actions were followed up and closed to ensure they were complete. In their action plan the practice told us they would maintain a central library of significant events; however, we could not find a chronological, accurate log or summary of significant events that allowed progress against action agreed to be monitored and reviewed and for trends to be identified. This meant there was limited oversight and management of issues and risks.

For example, for a significant event related to lack of clarity from secondary care about the frequency and strength of medicines to be administered to a patient, the agreed action was to feed this back to the hospital department as a basic safety measure. Whilst the practice was able to show us on the day of the inspection that this had been done, the records of significant events did not indicate that this was the case.

Another example was that of a patient with the same name as another patient mistakenly being given the other patient's 'normal' test results. Subsequently the same patient received their own correct results which were 'abnormal'. On both occasions the patient was informed by a member of the reception team, when it was practice policy for the patient to be informed by a practice nurse. We could see from the significant event form that the patient had subsequently been informed of the correct results and apologised to about the previous mistake. The receptionist team had been advised via email to be aware of patients with the same name. However, there were no details of any other investigation, discussion or action being taken and by whom, for example why the patient had been contacted by the reception team instead of a practice nurse and what had been done to prevent future re-occurrence. On the day of the inspection and subsequently, there was limited knowledge of this incident amongst the leadership team.

We saw that the practice had a clear complaints policy which set out how to complain, what to expect

in terms of a response and how to escalate the complaint if still not satisfied with the outcome. We found that in most of the complaints we looked at, the outcome was explained appropriately to the individual and an apology provided where appropriate.

However, we found that the practice's records did not enable accurate monitoring of the complaints process. For example, dates complaints had been received, and dates they were acknowledged were not monitored against the practice policy. From the complaints we looked at we saw that timescales specified within the policy were not always met. We also found it difficult to locate the relevant correspondence relating to complaints identified in the practice's overall summary of complaints. For example, in the complaints summary record 1/4/2019 to 31/3/20, 11 complaints were recorded but only three complaints were found in the hard copy complaints folder. Also, none of the practice's responses to these complaints were kept in this folder which made it hard to track the outcome. Some complaints records were stored electronically but these were also incomplete. The practice therefore did not have an effective process for managing this process.

At this inspection we also found that the practice had still not implemented a system for managing patient safety alerts. The practice told us that the practice manager received all patient safety alerts and emailed them to staff. New alerts were also highlighted in the weekly staff newsletter. However, there was no system for identifying who should take the lead on relevant safety alerts and ensuring appropriate action was taken in a timely manner. For example, identifying and re-calling relevant patients, arranging for contact and review of patients and reviewing and following up that appropriate action had been taken. The practice did not keep a log of alerts that recorded who they had been sent to, what action had been taken in response to and by whom and what follow up had taken place. There was therefore no oversight and assurance that appropriate steps were being taken to manage any risks to patients.

The practice told us that since the inspection they had started to implement a new team-based intranet system which enabled significant events and safety alerts to be recorded and shared with all staff systematically. It also provided an electronic monitoring system and audit trail of events which included completed actions. The practice showed us the system on the day of the inspection, however, implementation and oversight were not yet complete or embedded.

Continuous improvement and innovation

There was limited evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	N

Explanation of any answers and additional evidence:

We saw evidence which showed that some significant events were discussed at relevant meetings and that the learning that had been identified was shared at the meetings and in emails to relevant staff. The practice told us that only some significant events were discussed and shared, however there was no criteria in place for determining how these were selected.

We reviewed records of significant events and meeting notes and found that learning and improvements were not always appropriately identified. Learning points and action points were brief and were often identified as 'none'. For some events learning opportunities and actions for improvement were missed. For example, for one significant event the practice received a discharge summary that stated that the hospital had referred the patient under a two-week cancer referral rule for assessment. However, the practice discovered that the referral had not been made, so they referred the patient themselves. The practice identified that no changes in practice were required and that there was no learning to be gained or action to be taken. However, action could have included sharing the incident with the hospital so that they could investigate the root cause and take remedial action to prevent re-occurrence. Another event involved a patient requesting and previously receiving, a contra-indicated medicine to the one they were already taking. This could have had a serious health consequence. The action and learning recorded were only that clinicians should 'glance' and check the electronic notes page for contraindications of this type. No other improvements or actions were identified as a result of the event, for example undertaking an audit to identify patients taking this medicine and putting controls in place to prevent the prescribing of contra-indicated medicines. For another significant event that involved query over a diagnosis, the learning point was simply 'think outside the box', there was no detail about what this meant.

We saw from the practice's summary of complaints that, in line with their action plan, the practice had added columns to identify learning points, whether these had been disseminated and to whom. However, the learning points were very brief and for five out of 11 complaints the learning recorded was 'none'. Details of action taken because of complaints on the summary record were very brief. We saw that complaints were a standard agenda item at management meetings. However, there were no detailed minutes of these meetings. There were brief action points from the meeting, but it was difficult to determine what agenda items they related to. There was therefore limited evidence to show that learning from complaints had been identified and used to make improvements. For most of the complaints it was evident from the summary record that they were only shared with the individual involved which meant that learning was not routinely or effectively shared with the wider team to prevent similar future complaints. Discussions with the registered manager and practice manager on the day of inspection confirmed this to be the case.

For both significant events and complaints there was no system in place to follow up whether the learning or actions for improvement had been implemented.

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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)	≤-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.