

Care Quality Commission

Inspection Evidence Table

Dr P J P Holden & Partners (1-572203537)

Inspection date: 6 December 2019

Date of data download: 5 December 2019

Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Safe

Rating: Good

The practice was rated as requires improvement for providing safe services at the comprehensive inspection undertaken in December 2018. This was because:

- The provider did not have a comprehensive system in place to input clinical coding for safeguarding on appropriate patient records.
- The provider did not have effective arrangements in place to evidence staff immunisations, or provide a risk assessment in place of where this was not possible.
- The provider did not have effective systems to capture all types of incidents, including near misses, in order to ensure that all learning opportunities were maximised. Evidence that actions had been completed were not always clearly evidenced.

At the focused inspection completed in December 2019, we found that the provider had taken action to address these issues.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There were systems to identify vulnerable patients on record.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• A new GP partner had been appointed as the clinical safeguarding lead since our previous inspection.• The practice had set up an improved system to ensure the consistency of coding for safeguarding within clinical records.• The clinical system had been updated to produce a list of patients who needed to be reviewed at the next practice safeguarding meeting.• The practice had accurate adult and child safeguarding registers in place and these were updated on an ongoing basis, and reviewed at safeguarding meetings. The adult safeguarding register incorporated all vulnerable patients including patients living with dementia, mental health	

Safeguarding	Y/N/Partial
<p>difficulties and those with a learning disability. Relevant records were marked with an alert to ensure all staff were aware of these patients when they accessed their records. We observed that the system was working effectively.</p> <ul style="list-style-type: none"> • A meeting schedule to review vulnerable patients had been formulated to which both clinical and non-clinical were invited to attend, in order to improve awareness within the practice team. • Under 16s who did not attend planned hospital appointments were monitored. Parents or guardians would be contacted to query the reason for the non-attendance and this was coded and documented within the patient's record. If the child was on the safeguarding register, or if any further follow up actions were required, the GP would be notified to review this. 	

Recruitment systems	Y/N/Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had developed a staff immunisation policy since our previous inspection. This defined vaccination requirements for all staff, and the additional immunisations required for clinical staff. The policy included a risk assessment for completion by staff who declined to receive certain vaccinations and these were recorded on a staff immunisations register. We observed that the register was up-to-date. • The staff immunisation policy would be reviewed every three years and any risk assessments completed by staff would be subject to a five yearly refresh date. New staff were issued with the policy upon commencement of duties to ensure all immunisation details were recorded immediately, with any associated risk assessment also being completed at this time. 	

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
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Following the previous inspection, the practice had reviewed its management of significant events. They had labelled this as learning events to encompass significant events, lower level learning events, and near misses. • A revised reporting form had been introduced which incorporated a risk assessment to determine any priorities for action. • The practice had appointed a learning events lead who decided at which meeting the events will be discussed, for example, a specific learning events meeting, partnership meeting, clinical meeting or full staff meeting. Those of the more significant risk were reviewed at the next partnership meeting. 	

- We saw evidence that any associated learning and the outcomes achieved were documented in the minutes from regular learning events meetings.

Effective

At the previous inspection in December 2018, the population group of people experiencing poor mental health was rated as requires improvement due to high levels of exception reporting in some indicators.

At the focused inspection in December 2019, exception reporting levels had decreased and this population group is now rated as good.

People experiencing poor mental health (including people with dementia) Population group rating: Good

Findings

- We observed that exception reporting rates relating to some mental health indicators had reduced since our previous inspection.
- The practice assessed and monitored the physical health of people with mental illness by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. This would be picked up through the patient's annual review, although this excluded a number of patients who had been exception reported.
- The practice worked with wider members of the health community to address the needs of their patients, for example the local community mental health team.
- There was a system for following up patients who failed to attend for administration of long-term medication. Individual help was available to patients who needed support with any changes to their prescription, and staff alerted a GP if patients were not collecting their prescribed medicines (via established relationships with local pharmacies).
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe, for example, by engagement with local community health team.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.

Mental Health Indicators	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	95.1%	92.9%	89.4%	No statistical variation
Exception rate (number of exceptions).	22.6% (12)	15.5%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and	93.2%	92.4%	90.2%	No statistical variation

other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)				
Exception rate (number of exceptions).	17.0% (9)	13.6%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	77.8%	84.1%	83.6%	No statistical variation
Exception rate (number of exceptions).	11.0% (10)	8.4%	6.7%	N/A

Any additional evidence or comments

Exception reporting rates had reduced in the latest published QOF data:

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019). Exception reporting had reduced from 36.4% in 2017-18 to 17% in 2018-19.
- 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 (01/04/2018 to 31/03/2019) was showing a gradual decrease from 25.8% to 22.6%.
- The practice informed us that they were taking a more proactive approach to monitoring QOF performance and exception reporting.

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.