

# Care Quality Commission

## Inspection Evidence Table

### Leighton Road Surgery (1-582132545)

Inspection date: 20 November 2019

Date of data download: 20 November 2019

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

## Safe

At our previous inspection on 10 July 2019, we rated the practice as inadequate for providing safe services and this rating will remain unchanged until we carry out a further full comprehensive inspection within six months of publication of the report from July 2019.

At the July 2019 inspection we found:

- The system to manage medicine and safety alerts had not improved. We looked at two recent safety alerts that were issued since the February 2019 inspection, and found that they had not been actioned appropriately. Staff we spoke to were unaware of these alerts.
- Medicines that required additional monitoring were not appropriately managed. Records we looked at showed some patients were not receiving the appropriate blood tests at the necessary time.
- We saw evidence that fridges containing vaccinations and emergency medicines were accessible to the public and unlocked. Sharps bins were also not stored safely.
- Cleaning logs of rooms and multiple-use equipment were not maintained.
- Pathology results were reviewed in a timely manner however, appropriate action was not always taken.

At the November 2019 inspection we found:

- These arrangements had improved, and the practice had taken effective action to comply with the warning notice.
- The practice had reviewed the management of patient safety alerts and records we looked at confirmed the appropriate action had been taken.
- We looked at clinical records for patients that were prescribed medicines that required additional monitoring and saw that these were appropriately managed.

- **We saw fridges containing vaccinations had been moved into treatment rooms and were secured when not in use.**
- **We saw that sharps bins were no longer stored on desktops and were away from patient reach.**
- **Cleaning logs of equipment and rooms were kept in each consultation room and reviewed daily.**

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: At the July 2019 inspection we found: <ul style="list-style-type: none"><li>• Sharps bins were kept on desktops that would be accessible to children and patients during consultations.</li><li>• There were no cleaning logs kept of non-single use items such as blood pressure machines or examination couches.</li></ul> At the November 2019 inspection we found: <ul style="list-style-type: none"><li>• The practice had reviewed and amended the protocol for safe use and disposal of sharps. This now included details of sharps bins not being kept at a low height or at a desktop near where patients sit for consultations. We checked five consultation rooms and found that all sharps bins were kept safely and not overfilled.</li><li>• Each room had a cleaning log that was completed by the nurse at the beginning of the day. Rooms not in use would be marked and not cleaned. These would be collected and reviewed at the end of each week.</li></ul>	

## 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
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
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
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the July 2019 inspection we found:</p> <ul style="list-style-type: none"> <li>• Fridges containing vaccinations and emergency medicines were unlocked and in a patient accessible area. We also saw that emergency medicines were held at a low level in a patient accessible area.</li> <li>• We checked records of patients who were prescribed medicines that needed additional monitoring and saw that appropriate blood monitoring was not always completed.</li> </ul> <p>At the November 2019 inspection we found:</p> <ul style="list-style-type: none"> <li>• Fridges containing medicines had been moved into treatment rooms and secured when not in use. The practice had installed covers over the plug sockets to ensure they were not accidentally unplugged. We saw that the temperature of these fridges was checked regularly. The practice had reviewed the protocol for drug and vaccine storage and shared this with staff.</li> <li>• The emergency medicines and equipment had been removed from an accessible area and was held securely behind reception. The practice had considered the safety of this location and was installing black-out blinds to ensure the medicines could not be seen from outside the practice.</li> <li>• We looked at patients who were prescribed medicines for mental health conditions and cancer that required additional monitoring. We saw that patients had not been prescribed these medicines without the appropriate blood tests. The practice had reviewed the protocol for the management of these medicines and administration team were now involved in highlighting overdue monitoring and contacting patients.</li> </ul>	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the July 2019 inspection we found:</p> <ul style="list-style-type: none"> <li>• Recommendations made at the February 2019 inspection had not been acted on.</li> <li>• We looked at two recent safety alerts for thyroid medicine and diabetic medicine that were published in February 2019. We found that appropriate action had not been taken. We saw examples where patients had not received appropriate information regarding their medicines in line with these alerts. Staff we spoke with were not aware of recent medicine and safety alerts.</li> </ul> <p>At the November 2019 inspection we found:</p> <ul style="list-style-type: none"> <li>• The practice had implemented a new protocol to manage safety alerts that included weekly meetings with the clinical pharmacist. They had also created a log of safety alerts that had been received, patient searches that had been completed and actions that had been taken. We saw examples of actions taken on recent alerts for example, regarding sodium valproate. Staff we spoke with were aware of recent safety alerts.</li> </ul>	

## Effective

At our previous inspection on 10 July 2019, we rated the practice as inadequate for providing effective services and this rating will remain unchanged until we carry out a further full comprehensive inspection within six months of publication of the report from July 2019.

At the July 2019 inspection we found:

- We saw evidence of a lack of clinical oversight and clinical systems to ensure patients were appropriately entered onto disease registers.
- We saw examples of abnormal blood results not being actioned or followed up. We also saw examples of patients who had not attended appointments not being followed up.
- We saw evidence of patients being inappropriately exception reported who had not had the appropriate follow up. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

At the November 2019 inspection we found:

- These arrangements had improved, and the practice had taken effective action to comply with the warning notice.
- The practice had completed patient searches and reviews of patients with diabetes to ensure they were correctly entered onto disease registers and had appropriate follow up.
- The practice had reviewed the system for managing pathology results. We saw evidence that pathology results were being actioned appropriately.
- Clinical records that we reviewed showed that exception reporting was being completed appropriately.

Effective needs assessment, care and treatment

**Patients' needs were assessed regularly, and treatment was followed up where necessary.**

	Y/N/Partial
Patients' treatment was regularly reviewed and updated.	Y
Explanation of any answers and additional evidence: At the July 2019 inspection we found: <ul style="list-style-type: none"><li>• The system to manage pathology results was ineffective and we saw that abnormal blood results were not acted on in a timely manner.</li><li>• We saw examples of where blood results that may have indicated a diagnosis of diabetes had</li></ul>	

not been followed up or invited into the practice for further treatment.

At the November 2019 inspection we found:

- The practice had amended the system for managing pathology results that included trained administrative staff dealing with results that did not require any further action. Any abnormal blood results, or blood results within a set criteria, for example all prostate cancer markers, would be reviewed daily by a GP. The protocol detailed that all pathology results would be actioned within 24 hours of receipt and we saw evidence that this system was effective.
- The practice had improved the recall of patients with abnormal blood results and patient searches were completed weekly to highlight any patients that had not responded to invites into the practice. These patients were then contacted by administration staff.
- The practice had completed an audit of patients with blood results that may indicate a diagnosis of diabetes. All of these patients had been contacted and invited into the practice. We looked at records of patients who currently had blood results that may indicate diabetes and saw that all of these patients had been contacted and many had appointments booked for further investigation and discussion.

Diabetes Indicators	Practice	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	90.0%	80.4%	79.3%	Variation (positive)
Exception rate (number of exceptions).	25.5% (225)	16.2%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	64.5%	75.9%	78.1%	Tending towards variation (negative)
Exception rate (number of exceptions).	7.9% (70)	12.7%	9.4%	N/A

	Practice	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	69.5%	83.5%	81.3%	Variation (negative)
Exception rate (number of exceptions).	12.2% (108)	14.2%	12.7%	N/A

### Any additional evidence or comments

At the July 2019 inspection we found:

- Exception reporting within diabetes was higher than national and local averages. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.) We reviewed records for some diabetic patients and found that patients had received minimal follow up, monitoring or review prior to being excepted.

At the November 2019 inspection we found:

- Exception reporting was lower than local and national averages in two diabetes indicators.
- The practice had completed an audit of a selection of excepted patients to ensure this had been completed appropriately and patients had been followed up as necessary.
- We looked at clinical records of patients that had been excepted and saw that this had been completed appropriately.

## Responsive

At our previous inspection on 10 July 2019, we rated the practice as inadequate for providing responsive services and this rating will remain unchanged until we carry out a further full comprehensive inspection within six months of publication of the report from July 2019.

At the July 2019 inspection we found:

- The practice had not completed any patient surveys to ascertain the views of patients particularly in relation to access.
- Results from the most recent national GP patient survey published in July 2019 highlighted a significant drop in patient satisfaction since the last published results in 2018.
- Patients told us there was difficulty in accessing the practice by telephone and getting a routine or urgent appointment when they needed. Patients also told us that the phone lines would regularly cut out during phone calls and we saw examples of this happening on the day of inspection.
- Some staff told us they felt there was not enough provision for face to face appointments.

At the November 2019 inspection we found:

- These arrangements had improved, and the practice had taken effective action to comply with the warning notice.
- The practice had completed a patient survey that showed low patient satisfaction. Since this survey, the practice has increased clinical capacity, implemented a new telephone system and relocated the reception team.
- The practice was in the process of completing a capacity and demand study in order to analyse and respond to patient need.
- The newly implemented telephone system was more reliable and allowed for monitoring of queue length and waiting times.
- Patients and staff told us there was increased face to face provision and appointments could be offered where needed.

## Responding to and meeting people's needs

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the July 2019 inspection we found:</p> <ul style="list-style-type: none"><li>• The practice had not carried out patient feedback surveys in relation to areas of challenge, for example access.</li><li>• The practice had not identified patient demand in order to streamline services.</li></ul> <p>At the November 2019 inspection we found:</p> <ul style="list-style-type: none"><li>• A patient survey had been completed in October 2019 to ascertain the views of patients in relation to access. This looked at patients views over the previous six months and showed low levels of patient satisfaction in relation to telephone access and ease of getting appointment. This reflected the GP Patient survey results. The practice had planned to repeat this survey in February 2020 to assess if the changes made have resulted in improvement in patient satisfaction.</li><li>• The practice was in the process of completing a capacity and demand study in order to identify where the highest patient need is. We saw evidence that reception staff were collating this data on a daily basis. The practice told us this information would be analysed at the end of November 2019 with a view to rearrange clinician appointments as necessary.</li></ul>	

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
20592.0	290.0	120.0	41.4%	0.58%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019)	94.0%	94.2%	94.5%	No statistical variation

## Timely access to the service

### National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
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 (01/01/2019 to 31/03/2019)	17.1%	N/A	68.3%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	32.5%	63.1%	67.4%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	37.0%	60.2%	64.7%	Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	44.3%	70.3%	73.6%	Significant Variation (negative)

Any additional evidence or comments
<p>At the July 2019 inspection we found:</p> <ul style="list-style-type: none"> <li>• Results of the GP Patient survey were significantly below national and local averages. The practice did not have a formal plan to address this.</li> <li>• The practice had lower clinical capacity than was needed for the patient population. The practice relied on locum staff. Locum staff we spoke to were not always aware of practice protocol.</li> <li>• Patients told us there was difficulty accessing the practice by telephone and that the phone system was unreliable, and calls would get disconnected.</li> <li>• Patients and staff told us there was often a lack of appointments and staff often had to redirect patients to other services, including NHS 111. At the time of this inspection, pre-bookable appointments were not available for six weeks.</li> </ul> <p>At the November 2019 inspection we found:</p> <ul style="list-style-type: none"> <li>• The practice had made positive changes in response to the lower than average GP patient results. The practice had increased the number of locum GPs in order to offer a higher number of appointments to the patient population. The practice was in discussion with these locum staff to take on permanent roles. Locum staff were invited to clinical governance meetings and were therefore aware of the practice policies and procedures and had the opportunity to share learning.</li> <li>• The practice had also increased the number of minor illness nurses and had recruited two locum</li> </ul>

paramedics to assist with home visits.

- The practice had moved the call-centre to the Grovebury Road surgery, where the majority of the clinical and administration teams are based and created a reception office. This has allowed for better communication between reception teams and clinicians.
- This office had increased space and resources for the reception team and the practice had installed a new telephone system that allowed staff to monitor telephone activity. On the day of inspection, we saw that the average waiting time for telephone calls had been just over one minute.
- The practice had also created an additional reception desk to manage patients who attended in person to book appointments.
- We saw that there was a higher provision of face to face appointments and pre-bookable appointments were available three days following the inspection. Reception staff told us that they did not regularly have to redirect patients to alternative provision.
- We saw that staff morale had increased and staff showed commitment and enthusiasm to improve the practice and the patient experience.

Source	Feedback
Patient interviews	Patients we spoke with told us that there was still some difficulty in accessing the practice via the phone however, this had vastly improved. Some patients told us there were considerable difficulties in getting appointments in the past and they had been surprised with the ability to get appointments in recent weeks or on the day of inspection.

## Well-led

At our previous inspection on 10 July 2019, we rated the practice as inadequate for providing well-led services and this rating will remain unchanged until we carry out a further full comprehensive inspection within six months of publication of the report from July 2019.

At the July 2019 inspection we found:

- Since the February 2019 inspection, clinical capacity had reduced, and the practice had not formally assessed the risk of this to patients or put in place any remedial actions.
- The reduction in clinical capacity had resulted in a lack of clinical oversight. Leaders had identified that patients had difficulty with accessing the practice; however, they did not have a formal action plan in place to address these challenges.
- The practice was unable to provide evidence that processes were in place to ensure that the patients who required emergency appointments were able to be seen in a timely manner.
- The practice did not conduct any form of assessment or audit to monitor appointment capacity or demand, despite the significant decrease in clinical capacity and levels of patient dissatisfaction particularly in relation to access.
- The practice had not completed any patient surveys or feedback exercises to seek patients' views.
- The practice had not completed any succession planning.
- Risks to patient safety were not appropriately managed including management of safety alerts, management of patients with long term conditions, patients prescribed high risk medicines, emergency medicines and sharps waste.
- Locum staff were not invited to practice meetings and did not have a clear understanding of practice processes.

At the November 2019 inspection we found:

- These arrangements had improved, and the practice had taken effective action to comply with the warning notice.
- The practice had increased clinical capacity and we saw evidence that access had improved. We saw that emergency appointments were available in a timely manner.
- We saw evidence that clinical oversight of long-term conditions had improved.
- A capacity and demand study had begun and was due to be analysed in December 2019.
- A patient survey had been completed. This showed low levels of patient satisfaction. A formal plan for improvement had been developed.
- The practice had completed formal succession planning.
- Risks to patient safety, such as management of patient safety alerts, medicines that require additional monitoring and sharps waste had been appropriately reviewed and effective management was in place.
- Locum staff were invited to practice meetings and were included in changes to practice protocol and shared learning.

## Leadership capacity and capability

There was a leadership development programme, including a succession plan.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the July 2019 inspection we found:</p> <ul style="list-style-type: none"> <li>The practice had not completed any succession planning.</li> </ul> <p>At the November 2019 inspection we found:</p> <ul style="list-style-type: none"> <li>The practice had developed a business continuity plan.</li> <li>The practice had created a staff succession planning document that included details of how to manage clinical and administration shortfall and unplanned absences.</li> </ul>	

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
Progress against delivery of the strategy was monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the July 2019 inspection we found:</p> <ul style="list-style-type: none"> <li>The practice had not developed an action plan to address the challenges they faced. They felt they understood the patient concerns around access however had not completed a patient survey.</li> </ul> <p>At the November 2019 inspection we found:</p> <ul style="list-style-type: none"> <li>The practice had completed a patient survey in October 2019. The results showed low patient satisfaction around access.</li> <li>The practice had created a formal transformation plan which outlined the structure for practice improvement. This included actions such as working with the PPG, reviewing clinician recruitment and analysing patient feedback. This plan included actions, responsible persons and timescales.</li> </ul>	

## Managing risks, issues and performance

	Y/N/Partial
There were effective arrangements for identifying, managing and mitigating risks.	Y
Explanation of any answers and additional evidence:  At the July 2019 inspection we found: <ul style="list-style-type: none"><li>• The practice did not have an effective risk management system in regard to safety alerts, emergency medicines and sharps waste.</li></ul> At the November 2019 inspection we found: <ul style="list-style-type: none"><li>• The practice had an effective system to manage risks to patient safety. These had been reviewed and we saw evidence that safety alerts, emergency medicines and sharps waste was effective.</li></ul>	

## 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.