Care Quality Commission

Inspection Evidence Table

Poole Town Surgery (1-542444974)

Inspection date: 9 January 2020

Date of data download: 07 January 2020

Overall rating: Good

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

Well-led Rating: Good

At our previous inspection of 23 January 2019, we rated well-led as requires improvement because:

- The practice was not able to demonstrate that all learning from significant events had been shared with all relevant staff.
- Not all staff had undertaken safeguarding adults and/or safeguarding children refresher training.
- The practice's recruitment procedures did not ensure that only persons of good character were employed.
- The arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were not operated effectively, in particular in relation to the fire safety tests and audits or the management of prescription storage.
- The provider was not aware that Quality and Outcomes Framework (QOF) exception reporting was higher than local and national averages.

At this inspection we saw that these issues had been addressed.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality

sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
At our inspection of 23 January 2019, the practice was not able to demonstrate that all relevant learning had been discussed with all relevant staff. At this inspection we saw this had been addressed. Minutes of the meetings showed that the learning from events had been discussed. There was a record of those who attended the meeting. There was a written staff circulation, outlining the learning, to staff members who had not been able to attend the meetings.	

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Staff interviews	Staff told that they felt valued by the doctors at the practice. There were regular staff meetings where they were encouraged to contribute. Staff contributions had changed the way the practice operated. For example, staff had suggested that the time scales for opening the practice in the morning were too tight. As a result, staff were paid to come in slightly earlier to prepare the practice for opening. Staff had suggested that some long term condition appointments were too short, and these appointment times had been extended.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
At the previous inspection we found that the practice's recruitment procedures did not ensure that only persons of good character were employed. At this inspection we saw that there were effective recruitment checks. All staff had records of vaccination status and had completed training in safeguarding adults and children to the appropriate level. Staff had had an appraisal during the previous 12 months.	

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
The practice had records which demonstrated safe security arrangements for the storage of prescription stationery. It was kept in locked cupboards and there were locks on each printer that held prescriptions. Fire safety issues had been addressed. There were weekly fire alarm tests recorded. Actions, identified in fire and health and safety audits, had been completed.	

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to adjust and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
At the inspection of 23 January 2019, the practice had not been aware that exception reporting for Quality and Outcomes Framework (QOF) data was higher than local and national data in some areas.	

Exception reporting is the removal of patients from QOF calculations where, for example, patients decline a review following three invitations or certain medicines cannot be prescribed because of side effects.

The inspection of January 2019 used the QOF data for the year ending March 2018 to help make the judgements about the level of exception reporting. Following the January 2019 inspection, the practice made changes to the processes for reviewing patient's treatment and for exception reporting. Changes included: sending personalised, as opposed to, standard letters and telephoning patients to check why, for example, they had not attended a review and to emphasise the importance of review.

The data in this report relates to the QOF year ending March 2019 two months after the inspection. Much of the exception reporting had already been done for that QOF year and the practice's changes were not well embedded by the QOF year end.

We reviewed the following data: -

At our previous inspection of 23 January 2019, the exception reporting of patients with diabetes had been of concern. At this inspection it was not a concern.

At our previous inspection of 23 January 2019, the percentage of patients with asthma, on the register, who had had an asthma review in the preceding 12 months and had been excepted from the QOF data had been 23%, at this inspection the most recent validated and publicly available data showed Asthma exception reporting was 30%.

At our previous inspection of 23 January 2019, the percentage of patients with Chronic Obstructive Pulmonary Disease who have had a review, undertaken by a healthcare professional, and had been excepted from the QOF data was 19%, at this inspection the most recent validated and publicly available data showed COPD exception reporting was 29%.

Exception reporting for diabetes had reduced below the level of concern. However, the data was still higher, than national and local averages, for asthma and COPD. Overall clinical exception reporting (taking all the QOF areas into account) was 12.4%, in line with the clinical commissioning group average of 11.6%.

The practice had identified reasons for the high exception reporting but not in sufficient time, January to March 2019, to impact on the data for QOF year under examination at this inspection. Reasons included; some diabetic patients had had their reviews in secondary care, but the coding, necessary to update the patient's record had not been completed. Exception reporting had happened when the patient did not respond to the third invitation, and not at the end of the QOF year. We found records of patients who had been exception reported, for example, in July, who had come to have their review in the following October.

Thus, the QOF data showed some patients as not reviewed when they had been, and others as excepted from the data when they should not have been.

The practice confirmed they had reviewed the exception reporting for COPD and Asthma patients since January 2019. However, at the time of inspection they were unable to demonstrate improvements. The practice had changed the processes so that these errors would not apply to current exception reporting, that is for QOF year ending March 2020. For example, by not excepting patients until the end of the QOF year.

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Any unusual access was identified and followed up.	Yes

Engagement with patients, the public, staff and external partners

The practice involved patients, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes

Feedback from Patient Participation Group.

Feedback
We spoke with one member of the patient participation group (PPG). They reported that the group had a useful relationship with the practice. The practice was open to suggestions. For example, in promoting coffee mornings for carers and supporting local support organisations such as those for people who were socially isolated.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

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

Examples of continuous learning and improvement
There was emphasis on leadership. For example, one of the managers at the practice had recently been selected to attend an NHS leadership and mentoring course.

The practice had recently signed up to an initiative designed to measure, objectively, how well the practice was supporting carers. We saw minutes of meetings where improvements and practical ideas were discussed, and documents that showed they had been implemented.

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.