Care Quality Commission

Inspection Evidence Table

Jarvis Medical Practice - GPCC (1-1783268868)

Inspection date: 9 June 2020

Date of data download: 03 June 2020

This inspection was carried out due to serious concerns about Jarvis Medical Practice being brought to the attention of the Care Quality Commission. Although we paused our routine inspections due to Covid-19, our regulatory role and core purpose of keeping people safe has not changed. The possible risks to patient safety were reviewed and a decision was made to carry out a focused inspection.

We have reported on what we found during the focused inspection. We have not applied an overall rating, or a rating for any key question or population group. Ratings will be assessed in the future.

Individual population groups have not been separately reported on.

Safe

This was a focused inspection. We did not look at all aspects of the key question.

Risks to patients

There were gaps in systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
Comprehensive risk assessments were carried out for patients.	No
Relevant staff were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	No
There was a process in the practice for urgent clinical review of such patients.	No

Explanation of any answers and additional evidence:

During the inspection we reviewed a sample of patient records from pre and post Covid-19 lockdown. We saw two examples of requests for patients who had breathing difficulties that were not assessed and actioned in a timely manner. One, a telephone consultation for a child, was not dealt with until three working days after the request. For another a relative contacted the practice to say they had not received the telephone consultation they requested. The GP recorded they would carry out a home visit later that day. Records showed that no visit, or any other contact, took place for 11 working days. No explanation for this was recorded.

We saw the record of a telephone consultation for a patient with back pain. There was no record of potentially serious causes of back pain being excluded, and no safety-netting was recorded. Safety-

netting is information given to a patient during a consultation about actions to take if their condition deteriorates or fails to improve.

Information to deliver safe care and treatment

Staff did not have the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	No
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	No
Explanation of any answers and additional evidence: During the inspection we reviewed a sample of patient records from pre and post Covid-19 lockdown. We saw many examples where records were not clear. What had been discussed during a consultation, safety-netting, red flag symptoms and routine reviews were not recorded in a way that reflected current guidance. We saw an example of the GP recording that they would arrange a rheumatology referral. This had not been completed.	

Appropriate and safe use of medicines

The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	No
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.	No

Effective

This was a focused inspection. We did not look at all aspects of the key question and we did not individually assess the population groups.

Effective needs assessment, care and treatment

Patients' needs were not assessed, and care and treatment was not delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	No
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	No
Patients' treatment was regularly reviewed and updated.	No
There were appropriate referral pathways to make sure that patients' needs were addressed.	No

Explanation of any answers and additional evidence:

During the inspection we reviewed a sample of patient records from pre and post Covid-19 lockdown. One patient had attended for a face to face appointment. They were concerned about a lump. There was no record of any examination taking place and no further tests had been arranged. It was recorded that patients could not be referred for scans due to Covid-19 and no further action was taken to exclude a significant underlying cause.

We saw telephone consultation records for a patient with back pain. There was no record of potentially significant causes of back pain being excluded, and no safety-netting was recorded.

We saw examples of patients requesting consultations by telephone or home visit where breathing difficulties were mentioned. These were not prioritised and there was no record of the urgency of the requests being assessed. There was no documented contact with these patients for several days.

One patient with multiple conditions and receiving palliative care was coded as being severely frail and housebound. A request for a home visit was made by a relative. There was no documented action until 11 working days later.

We looked at a sample of patients records where a high HbA1c level was recorded but a patient did not have a diagnosis of diabetes. A raised HbA1c level can indicate pre-diabetes or diabetes. Further investigation should be undertaken to confirm the diagnosis and ongoing review and monitoring should take place. We saw two examples of patients whose HbA1c levels indicated they might have diabetes, but this had not been followed up with repeat investigations. One patient's abnormal results were recorded as satisfactory in April 2019. Another patient had two HbA1c readings in the diabetic range in July 2015, confirming a diagnosis of diabetes. No diagnosis had been made and the patient had not been referred for screening or had appropriate reviews and monitoring.

We looked at the records of a diabetic patient who had an HbA1c level that could have resulted in significant harm and complications. It was recorded that a diabetic annual review had taken place but there had been no documented foot check and no referral to eye screening. Eye problems that can lead to sight loss if not found early can be caused by diabetes. Although a repeat blood test date was recorded, the period between tests was too long for a patient with this level of HbA1C.

We saw an example of the GP recording that they would arrange a rheumatology referral on 1 June 2020. At the time of the inspection this had not been made.

Responsive

This was a focused inspection. We did not look at all aspects of the key question and we did not individually assess the population groups.

Timely access to the service

People were not able to access care and treatment in a timely way.

	Y/N/Partial
Patients with urgent needs had their care prioritised.	No
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	No
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	No

Explanation of any answers and additional evidence:

We looked at a selection of requests for home visits. We found examples of these not being carried out and the patient not being contacted. We did not see examples of the urgency of medical attention following a home visit request being assessed.

Records were unclear so it was not always possible to determine when a home visit had taken place. The GP had recorded that he was unable to carry out a visit to a patient in a care home as he had been involved in an accident. The record was documented on a Saturday night, and it was recorded that the care home said there was no immediate concern and he would visit on the Monday if required. It was unclear when the visit took place as it was recorded at 0.57am on the following Tuesday that it had taken place at 0.51am on the Monday.

On a Tuesday in March 2020 a request for a visit to an elderly patient was made. On the Thursday a relative stated it had not taken place. The home visit was recorded as taking place four working days after the initial request and there was no recorded explanation of the delay and no recorded assessment of urgency.

On a Thursday afternoon a patient telephoned to request a home visit. They telephoned the practice the following Monday to complain that they had waited all day Friday, and no-one attended. We checked the records and the GP had recorded that the patient had telephoned to cancel the visit. The GP had input this the following Monday after the complaint had been made. This record was inaccurate as the time the visit was recorded as having been cancelled was before the time it was requested.

A visit for a vulnerable patient with mental health needs was made. The patient was coded as being housebound. There was no record of this visit taking place.

On a Monday in June 2020 a telephone consultation was requested for a child with breathing difficulties. No contact was made by the practice until three working days later. There was no recorded explanation of the delay and no recorded assessment of urgency.

The relative of a housebound patient receiving palliative care requested a consultation, saying they had not received a requested telephone call from the GP the previous day. The GP recorded that he would visit that day, but no recorded contact was made with the patient until 11 working days later. There was no recorded explanation of the delay and no recorded assessment of the urgency.

Well-led

This was a focused inspection. We did not look at all aspects of the key question.

Leadership capacity and capability

Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	No
They had identified the actions necessary to address these challenges.	No
Explanation of any answers and additional evidence: The practice had two partners; the GP and the practice manager. There was also a business manager. The leadership team had not identified the issues we found during the inspection, and did not display an awareness of the issues. The issues we identified could have a serious and adverse impact on patient safety and care but this had not been recognised.	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No
There were processes to manage performance.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
Explanation of any answers and additional evidence: Although the practice had formal systems in place these had not identified the issues found during the inspection. The two partners were the GP and the practice manager, and all other GPs were locums. The effectiveness of the GP was therefore not formally assessed or challenged by the practice.	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	No
There were effective arrangements for identifying, managing and mitigating risks.	No

Explanation of any answers and additional evidence:
The patient records we reviewed were of a poor quality. At times we were unable to determine what had occurred during a consultation as the recording was difficult to understand.

As stated previously in the evidence table we saw examples of inaccuracies in patients records. These included the GP entering a record stating a patient had cancelled a home visit request when evidence suggested this was not the case. We saw records indicating home visits had taken place in the middle of the night, prior to a visit request being received. The GP did not always make consultation entries contemporaneously.

Some records were very unclear with conflicting clinical information being recorded during the same consultation. We saw one consultation had been recorded as a both telephone consultation and a home visit. From the records it was not clear what the consultation request had been for.

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.