

Care Quality Commission

Inspection Evidence Table

Fusehill Medical Practice (1-9586218623)

Inspection date: 01 October 2020

Date of data download: 09 October 2020

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse but some of these needed improvement.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
Policies and procedures were monitored, reviewed and updated.	Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Policies and procedures for safeguarding were in place, but these were not regularly kept up to date and were not being followed. For example, we saw that the safeguarding register had not been audited and updated in the past 18 months, meaning patients who may have been put on safeguarding plans during that time would not be showing on the practice's system. This could result in patients who were at risk of harm not being identified and receiving adequate support.• We saw from the medical records that children on the safeguarding register were not being reviewed and that conversations with other professionals were either not taking place or were not being recorded. We saw examples of children on the register who had no entries in their records in the past two years to show that they had been reviewed at the practice or discussed with other professionals despite them having been admitted to hospital and having not subsequently attended the practice for their routine immunisations.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">We saw that additional cleaning was taking place between appointments as a result of Covid-19. The practice had sufficient supplies of PPE and these were being appropriately managed.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
There was an effective induction system for temporary staff tailored to their role.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice was able to call on support from the provider to cover staff absences, as they were able to source locum clinical staff from their other services if the practice was understaffed. However, as the long-term regular GPs at the practice were not on permanent contracts they were able to choose when to work. We saw that this had resulted in most of the regular practice GPs being on leave during the month of August 2020. We were told that getting locum cover was sometimes difficult, and occasionally locums worked remotely rather than from the practice. Staff told us they sometimes felt concerned about clinical staffing levels and that this had been raised with the provider.Data from our CQC Insight tool showed that 29.1% of clinical sessions in the past twelve months had been undertaken by locum GPs, compared to a local average of 3.8%. This higher-than-average use of temporary GPs combined with a lack of lead roles meant there was reduced clinical oversight at the practice. This in turn meant there was no formal oversight of the locum GP or the advanced care practitioner consultations. We were told of a healthcare professional raising concerns about a consultation carried out by a locum GP. We also saw an example where a locum GP had made an inappropriate comment in a patient's medical record. Once the provider was aware of this they told us they would take action to make sure this would not happen again.There was an induction for locum staff which included safety information, such as the fire evacuation procedure. However, despite there being a signature sheet at the back of the pack to confirm the induction was complete, none of the forms we saw had been signed. We were told the practice did not keep these forms once they had been signed by the locum staff but they would do so in future.	

Information to deliver safe care and treatment

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

	Y/N/Partial
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Partial
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> There were systems in place to monitor referrals, discharge letters, and test results, however we were told there was no formally designated lead person for each of these systems, meaning there was no continued oversight to ensure they were carried out regularly and promptly. We saw that this resulted in there being no follow up when things were missed, or that actions were being marked as completed when they had not been. For example, we saw mental health reviews which had been coded as having been completed when the records showed the patient had not attended. We saw that the provider carried out a workflow audit to ensure that tasks such as checking test results or referrals had not been missed. However, this was run on a six-monthly basis, which meant that results or referrals may have been overdue by the time they were discovered. We also saw that the latest version of the workflow audit had been run over 12 months ago in September 2019. 	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimization, but these required improvement.

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.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Processes for the safe handling of requests for repeat medicines and structured medicines reviews for patients were in place, but we were told that designated lead roles had not been established to ensure these were always carried out correctly, promptly, and regularly. As such 	

Medicines management	Y/N/Partial
<p>the systems relied on staff checking them when they thought to do so. We saw examples of patients who repeatedly missed blood tests but as this was picked up by a different staff member each time, the patient simply received a text message to tell them they were due a test, with no further follow up to ensure they attended. We saw that these patients then went on to receive their medications which should not have been prescribed without the blood test having been carried out first.</p> <ul style="list-style-type: none"> We saw that medication reviews were out of date, with searches for patients on certain high risk drugs which required three-monthly blood tests having not been run in the last six months. 	

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
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
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.	Partial
Number of events recorded in last 12 months:	8
Number of events that required action:	8
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Written complaints were also discussed as significant events so that learning could be shared with the team. We were told that locum GPs were not involved in discussing the outcomes and learning from significant events, despite the high usage of locum GPs at the practice. 	

Example(s) of significant events recorded and actions by the practice.

Event	Specific action taken
High temperature recorded on vaccines refrigerator.	Vaccines were quarantined while advice was sought from relevant authorities. A fault with the external refrigerator thermometer was identified and action was taken to ensure vaccines were preserved.
Medication error at pharmacy.	Patient was given wrong medicine at pharmacy and subsequently brought it to the practice to check. The GPs checked the prescription and found it was correct but the wrong medicine had been dispensed. Staff worked with the pharmacy to ensure the right medication was dispensed and

the wrong medicines were destroyed.

Effective

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

People with long-term conditions

Findings
<ul style="list-style-type: none"> Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. The practice had commissioned external staff who had received specific training to carry out reviews of some patients with long-term conditions. This was because the practice had employed three new practice nurses in March 2020 who had not all been trained in completing asthma and diabetic reviews. We were told that this training was not available due to the disruption caused by Covid-19 but that some in-house training had been offered by the provider.

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) <small>(QOF)</small>	73.7%	78.5%	76.6%	No statistical variation
Exception rate (number of exceptions).	18.8% (97)	18.2%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	91.8%	91.2%	89.4%	No statistical variation
Exception rate (number of exceptions).	19.4% (38)	14.0%	12.7%	N/A

Indicator	Practice	CCG	England	England
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		average	average	comparison
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	94.9%	92.8%	91.8%	No statistical variation
Exception rate (number of exceptions).	14.5% (20)	5.9%	4.9%	N/A

Any additional evidence or comments

The provider had a policy for exception reporting which detailed the criteria in which a patient could be excepted from the results. (Exception reporting allows practices to exclude eligible patients from indicators or an entire clinical domain of the Quality and Outcomes Framework (QOF) under certain criteria). This included where patients had had a minimum of two invites to review and had not responded (three invites in the case of cervical screening). Clinicians we spoke to were unsure why the numbers were higher than average. We were told there used to be a lead member of staff for reporting on the Quality and Outcomes Framework (QOF) but since this person left the role had passed to the practice manager with support from other staff within the practice and from the provider. We were told that clinical and administrative staff did not have lead roles for QOF areas.

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided, though this could have been improved.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	554.7	554.3	539.2
Overall QOF score (as a percentage of maximum)	99.2%	99.2%	96.7%
Overall QOF exception reporting (all domains)	9.2%	5.4%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Partial
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Partial

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

- An antimicrobial audit was carried out in December 2019 to ensure GPs were prescribing these drugs correctly. This found a 96% compliance rate with antimicrobial prescription protocol. The audit was run again in July 2020 and compliance had increased to 99.6%.

Any additional evidence or comments

We were shown the audit schedule for Fusehill Medical Practice. This showed a number of audits

which were due to be completed throughout the year. The audits which took place at the practice were safety or administrative audits, such as complaints, patient feedback, or infection control. We saw that there were clinical audits carried out “centrally”, as in by the provider and the results were shared with the practice. There were also some audits conducted centrally with practice involvement. We were told medical staff at the practice carried out clinical audits for their personal appraisals.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Partial
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y*
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y

Explanation of any answers and additional evidence:

- There was an induction for locum staff which included safety information, but none of the signature sheets to confirm the induction was complete had been signed.
- The practice had employed three new practice nurses in March 2020 who had not had training in undertaking asthma and diabetic reviews. We were told that this training was not available due to the disruption caused by Covid-19. The practice was aware of this and had taken steps to address this, ensuring patients had access to reviews and that training would be given as soon as it was available.
- Staff we spoke to told us they felt supported. There were supervisors in place for new staff, including the new nurses. Nurses told us they had clinical supervision from the GPs.

Responsive

Timely access to the service

People were able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We reviewed the appointment system in real time on the day of the inspection and found there were a range of appointments available. Face to face appointments with patients were currently reduced due to restrictions in place as a result of Covid-19. The practice was operating telephone, video, and online consultations to ensure that patients still had access to a GP. There was a “How to” guide on the practice website to help patients to understand online consultations and how they were used. A message on the practice phone line advised patients that online consultations were now an option but that patients could still use the telephone to book an appointment if they wished. The practice was aware of lower than average feedback about telephone access. They had recently appointed new reception staff to increase the number of people answering calls at busy times and were also encouraging patients to use online consultations as an alternative. 	

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 (01/01/2020 to 31/03/2020)	43.9%	N/A	65.2%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	58.0%	68.4%	65.5%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2020 to 31/03/2020)	49.3%	64.9%	63.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020)	60.7%	76.0%	72.7%	No statistical variation

Well-led

Governance arrangements

The overall governance arrangements required improvements.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>While governance structures and systems were in place, we saw there were gaps in these which could potentially lead to risks, for example:</p> <ul style="list-style-type: none"> Formally designated lead roles had not been established for the safe handling of requests for repeat medicines and structured medicines reviews. As such, we saw that patients received medications which should not have been prescribed without the blood test having been carried out first and that searches for patients on certain high risk drugs which required three-monthly blood tests having not been run in the last six months; There was no formally designated lead person to monitor referrals, discharge letters, and test results to ensure they were regularly checked and actioned. We saw that this resulted in there being no follow up when things were missed, or that actions were being marked as completed when they had not been. For example, we saw mental health reviews which had been coded as having been completed when the records showed the patient had not attended; The provider carried out a workflow audit to ensure that tasks such as checking test results or referrals had not been missed, but this was run on a six-monthly basis which meant that results or referrals may have been overdue by the time they were discovered. We also saw that the latest version of the workflow audit had been run over 12 months ago in September 2019; There was a higher-than-average use of temporary GPs, and a lack of clinical oversight at the practice. This in turn meant the oversight of the locum staff was not as robust as it should have been. 	

Managing risks, issues and performance

There were processes for managing risks, issues and performance but improvements were required.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Y

There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• The safeguarding register had not been audited and updated in the past 18 months, meaning patients who may have been put on safeguarding plans during that time would not be showing on the practice's system.	

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)	≤ -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.