

Care Quality Commission

Inspection Evidence Table

NHUC Beggarwood Practice (1-7680262453)

Inspection date: 6-13 March 2021

Date of data download: 26 February 2021

Overall rating: Not Rated

In order to seek assurances around potential risks to patients, we carried out a GP Focused Inspection Pilot (GPFIP) of NHUC Beggarwood Practice between 6 March 2021 and the 13 March 2021, to follow up on information received relating to this provider. We did not rate the practice or any key lines of enquiry during this focused inspection.

Safe

Rating: Not rated

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 was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Y
Staff who acted as chaperones were trained for their role.	Y
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.	Y
Explanation of any answers and additional evidence: All staff we spoke with were able to explain the process for raising safeguarding concerns and knew where to access up to date procedures when required. We reviewed clinical meeting records, which demonstrated that representatives from the practice attended multidisciplinary safeguarding meetings.	

Safeguarding	Y/N/Partial
<p>Minutes from practice team meetings showed that safeguarding concerns were a regular agenda item.</p> <p>We were told that due to the pressures of the pandemic, updated safeguarding training was provided through virtual educational events, provided by the Local Medical Council. Nursing staff and one GP had also attended a safeguarding workshop in November 2020.</p> <p>We saw that all staff had undertaken safeguarding training appropriate to their role. For example, administrative staff were trained to level one and clinical staff to level three.</p>	

Risks to patients

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

	Y/N/Partial
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Administrative staff were able to describe the actions they should take in the event of a patient's condition deteriorating whilst on site. Staff could also give examples of symptoms and conditions, which a patient might describe on the phone, which would prompt them to signpost the patient to NHS 111 or to dial 999 for an emergency ambulance. For example, call handlers have a script to follow if a caller describes symptoms of heart attack or potential sepsis.</p>	

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
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	P
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results, and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	P
Explanation of any answers and additional evidence:	

We looked at the clinical records of patients and checked the quality of record keeping and found that not all patient records had been updated appropriately.

For example, when reviewing records of patients prescribed the anticoagulant (blood thinning) medicine warfarin it was unclear where the clinical team recorded the most up to date warfarin levels. Patients taking warfarin should have a regular blood monitoring test. The test measures how much time it takes for your blood to clot and will determine if you are receiving the right dose of warfarin. It was unclear where the result was recorded prior to the patient receiving their warfarin prescription, as the results were not recorded in the notes we reviewed.

At the time of the inspection there was no clinical lead at the practice. Staff told us that there was a GP on duty each day who would review clinical information coming into the practice and undertake action to address any outstanding tasks. We did not see evidence that there was sufficient oversight, to ensure results were followed up in a timely manner.

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2020 to 31/12/2020) (NHS Business Service Authority - NHSBSA)	0.74	0.71	0.76	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2020 to 31/12/2020) (NHSBSA)	8.7%	8.6%	9.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2020 to 31/12/2020) (NHSBSA)	5.46	5.21	5.33	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	50.0‰	91.1‰	126.9‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group	0.55	0.71	0.67	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
Age-sex Related Prescribing Unit (STAR PU) (01/01/2020 to 31/12/2020) <small>(NHSBSA)</small>				

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
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.	P
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	P
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed 42 clinical records of patients who were being prescribed medicines that require monitoring. We found that eight of those patients were overdue a medicines review. Staff told us that reviews were undertaken when a patient attended an appointment but there was no robust system to ensure patients were receiving the appropriate medicines for their ongoing best health.</p> <p>For example, there were 19 patients registered with epilepsy. We reviewed the notes of three of those patients and found two had not received a timely review of their medicines. One patient was due a medicines review in January 2021 and another in September 2020. Similarly, of the 47 patients with a diagnosis of chronic obstructive pulmonary disease (COPD), we reviewed three records and found one patient did not have a medicines review recorded since January 2020, however, there was a COPD review completed in July 2020.</p> <p>On review of three records for patients prescribed a medicine used to treat high blood pressure and heart failure, we found two of the three records were not fully up to date. For example, one patient was prescribed a medicine to reduce their blood pressure in March 2021, but the last blood pressure monitoring was recorded in December 2019. Another patient was issued a prescription used to reduce the risk of stroke for patients who have high blood pressure, in February 2021. The record did not show that the patient had up to date blood test monitoring (January 2020) or up to date blood pressure monitoring (February 2020).</p>	

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
The practice monitored and reviewed safety using information from a variety of sources.	Y
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.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff understood their duty to raise concerns and report incidents and near misses. There were systems in place for reviewing and investigating when things went wrong.</p>	

The practice had recently updated their comprehensive Incident Management Policy (October 2020), and their procedures to be carried out following receipt of notification of death (March 2021) following an incident that occurred in September 2020.

Effective

Rating: Not rated

Effective needs assessment, care and treatment

People with long-term conditions

Findings

Patients with long-term conditions were not always offered a structured annual review to check that their health, treatment and medicines needs were consistently met. GPs explained that there was no clear pathway to ensure that everyone received a timely follow up appointment. However, staff maintained regular contact with patients throughout the pandemic to check if there were changes to long-term conditions of vulnerable patients. The GPs we spoke with also explained that patients would have their long-term condition checked opportunistically, when they attended for other specific concerns.

For example, we reviewed three samples of clinical records of 31 patients registered at the practice, who had a diagnosis of rheumatoid arthritis; all of whom had differing complex needs and co-morbidities which were being managed. However, all three patients were overdue a medicines review relating to their rheumatoid condition.

There were 247 patients registered with diabetes; we reviewed a sample of three records, two of the three had an up to date review of their condition and medicines (March 2021) and the third had been reviewed for their condition in July 2020, with a prescription review and update in February 2021.

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) (QOF)	84.2%	74.3%	76.6%	No statistical variation
PCA* rate (number of PCAs).	19.7% (90)	16.5%	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) (QOF)	77.8%	87.1%	89.4%	No statistical variation
PCA rate (number of PCAs).	2.2% (1)	17.2%	12.7%	N/A

The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	73.5%	76.9%	82.0%	No statistical variation
PCA rate (number of PCAs).	5.6% (4)	6.0%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	55.4%	63.7%	66.9%	No statistical variation
PCA rate (number of PCAs).	8.4% (17)	18.5%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	63.8%	67.6%	72.4%	No statistical variation
PCA rate (number of PCAs).	8.0% (44)	7.3%	7.1%	N/A
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)	81.4%	88.8%	91.8%	Tending towards variation (negative)
PCA rate (number of PCAs).	2.3% (1)	4.0%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	56.8%	72.2%	75.9%	Variation (negative)
PCA rate (number of PCAs).	6.4% (13)	13.6%	10.4%	N/A

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.	Y
The learning and development needs of staff were assessed.	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:	

The practice used an electronic training platform to provide most training courses for staff. The business and operations managers had oversight of staff training and this was being kept under review. We were provided with evidence to assure us that all staff had completed the required training relevant to their role.

Staff described the appraisal process; new staff had a 12-week follow-up review meeting after commencing their induction and then they agreed a six-month training plan.

Clinical staff accessed supervision from NHUCs director of nursing. All other staff received an annual appraisal.

The new operations manager (who started January 2021) arranged shadowing and training sessions with other local practices to enhance learning.

Well-led

Rating: Not rated

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.	P
They had identified the actions necessary to address these challenges.	P
Staff reported that leaders were visible and approachable.	P
<p>Explanation of any answers and additional evidence:</p> <p>Since the incident in September 2020 which prompted our inspection, the clinical GP lead and the practice manager had left the service.</p> <p>The senior team for NHUC had commissioned an incident investigation and report which was completed by an investigator from outside of the organisation. The Beggarwood Practice team were implementing actions to meet the recommendations identified in the report at the time of the inspection.</p> <p>The practice had recruited a new practice manager who was supported by the NHUC senior team. At the time of the inspection the senior team were also at the final stages of recruiting a GP to take on a clinical leadership role within the practice, and staff told us the overarching NHUC leadership team were always available and supportive.</p> <p>Nursing staff numbers had been insufficient to provide all the care to meet patients' needs in a timely way due to the effects of the Covid pandemic and retirement; the senior team were in the recruitment process to address this. Managers stated that recruitment was their biggest challenge currently.</p>	

Governance arrangements

There were not always 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.	P
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Governance structures and systems were embedded and maintained to reflect best practice. The structure flows from the NHUC executive committee; all policies, procedures and activities to ensure safety are reviewed, established and monitored to ensure effectiveness at this committee.</p> <p>Complaints and compliments, incidents and any quality issues are discussed at this meeting. The registered manager for the practice also presents quarterly reports to the local Clinical Commissioning Group (CCG). The clinical lead for this practice normally attended this meeting until they left the practice in January 2021.</p> <p>The weekly clinical meetings at the practice, which are attended by the GPs for the service, had been re-established in 2021. During 2020, meetings were irregular due to several staff suffering from Covid 19. These meetings included case studies led by nursing and medical staff.</p> <p>The practice submitted evidence of the nursing team meetings which showed the clinical and management issues discussed and demonstrated staff were involved and updated regarding issues relevant to them.</p> <p>However, we did identify some shortfalls regarding governance systems. For example:</p> <ul style="list-style-type: none"> • Medicines reviews were not always completed in line with recognised guidance. • The provider did not consistently record information in patient medical records to demonstrate that a clinical assessment, diagnosis and treatment plan was completed. • Not all patients diagnosed with a long-term condition had received a monitoring review of their Long-term conditions within the last 12 months. <p>The team were beginning to review leadership roles for clinical management of long-term conditions and other clinically vulnerable groups. For example, one of the GPs had agreed to lead medicines management and had started to attend the local medicines management forum.</p> <p>The practice is looking to recruit a prescribing pharmacist in collaboration with the Primary Care Network (PCN) which they feel would be a helpful support to the team.</p>	

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.	Y
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.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice provided evidence of recent audits completed by the advanced nurse practitioner in 2020. One audit was in relation to ensuring best practice regarding diabetes management for relevant patients. Another audit was regarding the practice's treatment of patients with a urinary tract infection using evidence-based guidelines.</p> <p>The staff member who undertook those audits had since retired but staff continued to monitor actions and any new recruits would be expected to maintain high standards and improve results where appropriate.</p> <p>We also saw details of the ongoing 'Coding and Summarising Audit' which commenced in October 2020. We saw evidence that the practice is engaged in in the local Clinical Commissioning Group (CCG) enhanced Infection, Prevention and Control (IPC) audit, along with their own monthly Covid 19 IPC audit.</p>	

Appropriate and accurate information

There was not always 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.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	P
There were effective arrangements for identifying, managing and mitigating risks.	P
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We found that oversight of clinical governance did not routinely ensure that staff had access to information which was accurate and valid.</p> <p>The clinical records we reviewed demonstrated gaps in the management of chronic disease and reviews of patients' medicines.</p> <p>From the records we viewed, it was not always evident that the practice had assured itself that appropriate monitoring of patients had taken place prior to prescribing medicines</p>	

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Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: Further to the investigation and report of the serious incident which occurred in September 2020, the practice had reviewed and updated policies to ensure a similar event would be managed effectively in future.	

Examples of continuous learning and improvement

The practice had improved their communication with families following a bereavement; for example, they had been sending bereavement cards to families since the beginning of January 2021 and made a couple of wellbeing calls to the next of kin before and after the funeral.

The practice has also approached a local funeral director for some advice on how to train staff in the techniques the funeral directors have when dealing with clients.

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.
- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)).
- **‰** = per thousand.