

# Care Quality Commission

## Inspection Evidence Table

### Drs Green, Broadbelt and Majeed (1-551429106)

Inspection date: 27 April 2021

Date of data download: 14 April 2021

### Overall rating: Good

At the last inspection in September 2019 the practice was rated good overall and requirements improvement in Well Led. The practice is now rated good for Well Led and remains good overall

### Well-led

### Rating: Good

At the last inspection in September 2019 the practice was rated requirements improvement in Well Led. At this review we spoke to the practice and reviewed evidence. The information demonstrated action had been taken, the requirement notice has now been met and recommendations had been actioned.

#### 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.	Y
They had identified the actions necessary to address these challenges.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: At the last inspection (September 2019) it was found that there were not robust systems in place to support quality review and monitoring for all activities. For example, there was no appointed infection control lead in order to address the challenges of and have responsibility for infection prevention and control. We identified that some performance indicators needed addressing such as prescribing of certain medicines, disease management and prevention. The practice had identified these issues and had commenced action to address them. The practice submitted evidence to support the updated action plan. The practice now has quality monitoring and review systems in place. These include risk assessments and protocols for, health and safety, infection control, emergency medicines and medicines held in GP bags. Performance indicators, staff training and professional requirements and development was also reviewed.	

The business plan they had implemented in 2019 had continued and was regularly updated. Risk assessments, including health and safety, have been updated and continue to be reviewed annually.

There is an overarching clinical governance policy (reviewed 2021) that sets out the principles of clinical governance and the expectations within the practice. There was a revised clinical audit plan and we saw evidence of completed audit cycles with actions/improvements taken following the audits.

The practice had investigated, and continues to monitor for improvement, prescribing performance indicators, undiagnosed cancer admissions and cancer screening uptake. They have carried out audits and introduced new systems, including safety netting all two-week rules to ensure patients receive an appointment and attend. Evidence was seen of discussion and actions taken in respect of performance indicators in meeting minutes.

Succession planning was evident. Recently a salaried GP had taken up post as a partner, a new salaried GP had been employed and the practice nursing staff compliment enhanced and developed. Evidence was seen in meeting minutes of discussions and involvement of staff.

## 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.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had developed a business development plan (2019-2022) which formally set out clear objectives about what they were trying to achieve and about the changes they would introduce. They considered the plan to be a live document. The document included measurable goals and objectives and was regularly updated.</p> <p>The business development plan was a standing agenda item at meetings and evidence was seen of progression of the plan. For example, practice nurse compliment enhanced and training and development of the practice nurses ongoing and completed.</p> <p>Discussion around the plan and strategy was seen in examples of meeting minutes we were sent as evidence.</p>	

## 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.	Y
Staff were clear about their roles and responsibilities.	Y
Explanation of any answers and additional evidence:  At the last inspection staff were not supported by clear systems, guidance and processes. There was not clear or sufficient monitoring of training and staff compliance with policies and processes. Patient feedback review was lacking.  At this review we found that improvements had been made.  There was an overarching clinical governance policy in place that had been recently reviewed. The document provided staff with information and guidance for clinical governance and how the practice will put this into action.  Clear monitoring of staff training and development was now in place. Staff appraisals were monitored along with professional registration and indemnity. The practice used Bluestream Academy for the majority of its training needs. Monitoring of training and development was now undertaken monthly by the practice manager.  Protocols and processes had been revised, updated and disseminated to staff. Staff were trained in new processes and systems and compliance monitored.  Processes for monitoring of medicines and calibration of equipment held in GP's home visit bags were in place and checks undertaken by the practice nurse.  There was a clinical audit plan in place that had been reviewed and continues to be reviewed on a quarterly basis. Changes and improvements made as a result of audits were documented and their effect monitored. The provider gave examples of improvements implemented as a result.  The provider explained how patient feedback was now collated and reviewed monthly, then disseminated to staff and the patient participation group for discussion. This was evidenced within meeting minutes.	

## 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 quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection (September 2019) policies, protocols and procedures were in place however their effectiveness and staff compliance with these were not reviewed. The infection control assessment was not complete. The health and safety risk assessment were incomplete and fire drill evacuations were not reviewed or appraised. Information/feedback from patients was not formally reviewed.</p> <p>The practice provided further evidence which demonstrated that an audit plan and programme was in place which included medicines management /prescribing, minor surgery and other performance indicators. We saw examples of audits having completed two cycles with improvements demonstrated. These were discussed at weekly and monthly meetings, examples of which were sent to us as evidence.</p> <p>Fire drills were now fully documented and reviewed after each episode. Logs were kept of fire drills and dates when they were next due diarised.</p> <p>Risks assessments had been completed with regards to health and safety, infection prevention and control, COVID19 and building security. The general business continuity plan and the COVID19 pandemic business continuity plan have recently been reviewed and are up to date.</p>	

**The practice had systems in place to continue to deliver services, respond to risk and meet patients’ needs during the pandemic**

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y

Staff were supported to work remotely where applicable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had reviewed and enhanced how it dealt with infection prevention and control (IPC). The practice nurse was the lead for IPC and undertook regular monitoring and auditing of IPC policies and processes. Staff were trained in IPC and COVID19 specific training had been undertaken, such as PPE donning and doffing. Training was monitored for compliance.</p> <p>COVID19 specific risk assessments were in place, reviewed and updated as required. Individual staff risk assessments were also seen.</p> <p>The practice detailed the delivery of services, the changes made and the affects the pandemic had on the practice. They had responded and were meeting the needs in order to protect staff, public and patients. Staff were supported to work at home where needed and there had been no major adverse impact on the practice.</p>	

### 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 monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection data and information collected to improve performance was not responded to or the response was not timely e.g. antibiotics and hypnotics prescribing, patient feedback, information about emergency hospital admissions caused by undiagnosed cancers and other performance indicators.</p> <p>The practice had taken responsibility for monitoring and managing performance. They provided evidence which demonstrated that this had improved. Performance indicators were now monitored. Actions had been put in place in order to improve cervical cancer screening, bowel cancer screening and breast cancer screening uptake, medicines management and prescribing. The practice worked with the Primary Care Network (PCN), local pharmacists and other professional stakeholders in order to identify and act on initiatives for improvement. Prescribing is monitored and reviewed to ensure GPs were following the local area guidelines.</p>	

Patient feedback from the NHS Friends and Family Test and the National GP Patient Survey is now formally reviewed and acted on. We discussed examples of this.

## Engagement with patients, the public, staff and external partners

**The practice involved the public, staff and external partners to sustain high quality and sustainable care.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<p>At the last inspection feedback/comments in patient surveys and the NHS FFT results were not formally reviewed. There was no evidence that they were taken into consideration and used to aid future practice and service developments.</p> <p>At this review, the practice said that feedback from the FFT was collated monthly with comments distributed quarterly to staff and the patient participation group (PPG). Areas for improvement were acted upon and documented. The National GP Patient survey was last analysed in January 2021 with results and comments discussed. The FFT is currently suspended due to the COVID19 pandemic.</p> <p>Meeting minutes seen demonstrated staff were involved in planning and delivery of services. Staff were able to feedback and make suggestions to the service at various opportunities such as staff appraisals, meetings, audits and business plan developments.</p> <p>The PPG was active, however during the pandemic, they have not been able to meet face to face. The practice will continue to communicate with them via the telephone and by email.</p>	

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<p>The practice had acted upon the findings of the last inspection (September 2019) and had developed and improved systems and processes. Clinical governance had improved and there was now evidence</p>	

of quality monitoring and review systems in place. We saw evidence of review and learning from audits and reviews and saw actions taken to improve.

## Examples of continuous learning and improvement

The practice had improved the uptake of childhood vaccinations over the years and was now performing above the World Health Organisations lower target of 90% uptake.

The practice had improved the uptake of cervical cancer screening by working with Cancer Research UK and implementing initiatives. They had consistently achieved or were achieving above the target rate in 2021.

### 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)	$\leq -3$
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.
- **\*PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#) ).
- ‰ = per thousand.