

# Care Quality Commission

## Inspection Evidence Table

### Highcroft Surgery (1-542061967)

Inspection date: 12 August 2021

Date of data download: 22 August 2021

## Overall rating: Good

The practice remains rated Good following our previous inspection on 14 June 2021.

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

**Safe  
rated**

**Rating: Inspected but not**

#### 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 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.	Partial
Explanation of any answers and additional evidence: At this inspection we reviewed outstanding pathology test results and clinical correspondence, as indicated on the practice clinical system. The practice had a workflow management system where administration staff were trained to process incoming clinical correspondence by scanning in received letters and allocating them to relevant staff to review and take action as appropriate, for example, coding new diagnoses, booking appointments with a clinician, arranging blood tests, referring on to other services and passing onto clinicians to change prescriptions before filing the letters in individual patient records. At our previous inspection on 14 June 2021, we found there were 27 outstanding letters on the clinical system and 14 pathology results waiting to be processed. On the day of this inspection, we found approximately 2900 outstanding actions on letters received by the practice on the clinical system, which were at various stages of processing, and 415 pathology results outstanding. The backlog of letters had started after our previous inspection. Some letters were allocated to named individuals but the majority were assigned to a workflow optimisation group. We reviewed approximately 35 records and found:	

- Some letters had all necessary actions completed but had not been filed.
- A number of letters from 22 June onwards had not been coded.
- Some letters appeared to have partially completed actions with some follow up actions outstanding. These included patients with mental health conditions and those requiring medicines to be changed. We raised four such patients with the provider, which they reviewed immediately after the inspection and provided assurance of actions taken.

The number of outstanding actions on letters and pathology results reduced to approximately 2600 and 62 respectively by the end of our review. We had no concerns about pathology results as there was no significant backlog of them.

The practice told us they received an average of 227 letters per day over 12 months from August 2020 to August 2021. There was evidence of a documented process in place for dealing with correspondence using the workflow management system, and records of staff trained to carry out the activity. This included a triage process where any safeguarding and urgent letters were immediately forwarded to the relevant lead in the practice. The process described how a letter was scanned, coded and actions distributed to staff before being completed and filed; however there was no checking process to ensure whoever it was forwarded to completed their actions.

The practice told us the backlog had increased due to a number of staffing issues, including annual leave and resignations from two staff members who were trained to carry out workflow management. In addition, staff had to take time off through sickness absence and/or self-isolation after testing positive for COVID19.

The practice responded to this by holding weekend working sessions, in order to get up to date with the backlog. A salaried clinician also worked additional hours to process the letters. They had recruited three new receptionists who were due to start imminently, and would be trained to carry out this role, increasing the workflow team to six people.

Whilst our review did not find evidence of patient harm caused by the delay in processing correspondence, delays in processing correspondence and undertaking actions required, together with the letters not being filed in the patient records in a timely manner could potentially have an adverse impact on patient care.

Since the inspection, we received further assurance from the provider that new staff members had been recruited with training in progress, and regular meetings with the workflow management team had been scheduled to monitor and manage the risk of backlogs occurring in future.

## 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)	$\leq -3$
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](#) ). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
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- ‰ = per thousand.