Care Quality Commission

Inspection Evidence Table

The Royal Crescent Surgery (1-572968244)

Inspection date: 25 September 2018

Date of data download: 21 August 2018

Please note: Any Quality Outcomes Framework (QOF) data relates to 2016/17.

Safe

Safety systems and processes

Safeguarding	Y/N
There was a lead member(s) of staff for safeguarding processes and procedures.	Y
Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Policies were in place covering adult and child safeguarding.	Y
Policies were updated and reviewed and accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs)	Y
Information about patients at risk was shared with other agencies in a timely way.	Y
Systems were in place to highlight vulnerable patients on record. There was a risk register of specific patients	Y
Disclosure and Barring Service checks were undertaken where required.	Y

Explanation of any answers:
Two GPs were booked on their safeguarding update training in June 2018, however, due to circumstances outside of the practice's control, the training was cancelled. Those GPs had been re-booked on the next available training which was due to take place in October 2018.

Recruitment Systems	Y/N
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff who require medical indemnity insurance had it in place.	Y

Safety Records	Y/N
There was a record of portable appliance testing or visual inspection by a competent person Date of last inspection/Test: 23.11.17	Y
There was a record of equipment calibration Date of last calibration: completed 24.9.18	Y
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals	Y
Fire procedure in place	Y
Fire extinguisher checks	Y
Fire drills and logs	Y
Fire alarm checks	Y
Fire training for staff	Y
Fire marshals	Y
Fire risk assessment: Conducted six monthly by an external contractor. Date of completion 24.4.18	Y
Actions were identified and completed. The external contractor recommended actions for the practice to consider. For example, they identified that the main alarm board was old/faulty and should be replaced. This was completed in January 2018.	Y
Additional observations: At the April 2018 visit, detectors were identified as being over 10 years old and recommended for replacement. The practice had plans to complete this on a on a rolling programme.	
Health and safety Premises/security risk assessment? Date of last assessment: 4.4.18	Y

Health and safety risk assessment and actions Date of last assessment: Health and safety action plan updated July 2018	Y

Infection control	Y/N
Risk assessment and policy in place Date of last infection control audit: June 2018 The practice acted on any issues identified such as replacing toilet brushes, clearing of magazines in the reception area and cleaning the inside of clinical bins.	Y
The arrangements for managing waste and clinical specimens kept people safe?	Y

Any additional evidence
The practice had plans to assess staff on their handwashing effectiveness at their protected learning day in November 2018.

Risks to patients

Question	Y/N
There was an effective approach to managing staff absences and busy periods.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans were developed in line with national guidance.	Y
Staff knew how to respond to emergency situations.	Y
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
In addition, there was a process in the practice for urgent clinician review of such patients.	Y
The practice had equipment available to enable assessment of patients with presumed sepsis.	Y
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y

Information to deliver safe care and treatment

Question	Y/N
Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
The practice had a documented approach to the management of test results and this was managed in a timely manner.	Partial
The practice demonstrated that when patients use multiple services, all the information	Y

needed for their ongoing care was shared appropriately and in line with relevant protocols.	
Explanation of any answers: There was a process in place for the appropriate management of test results. However, this was not recorded. Test results would be sent to the GP who initiated the test. If the GP was away, the remaining GPs would pick up any outstanding results and deal with it in an appropriate and timely way.	

Appropriate and safe use of medicines

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) (01/04/2017 to 31/03/2018) NHS Business Service Authority - NHSBSA)	0.93	0.93	0.95	Comparable with other practices
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). (01/04/2017 to 31/03/2018) (NHSBSA)	7.9%	9.4%	8.8%	Comparable with other practices

Medicines Management	Y/N
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.	Y
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	Y
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example audits for unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were systems for the safe ordering, checks on receipt, storage, administration, balance checks and disposal of these medicines in line with national guidance.	N/A
Up to date local prescribing guidelines were in use.	Y
Clinical staff were able to access a local microbiologist for advice.	Y
For remote or online prescribing there were effective protocols in place for identifying and verifying the patient in line with General Medical Council guidance.	N/A

The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen on site.	Y
The practice had a defibrillator.	Y
Both were checked regularly and this was recorded.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	Y

Explanation of any answers:

- At the last inspection in November 2017, we found the practice had not taken action when there were signs that one of the vaccine fridges had operated outside of the normal range. At this inspection, we found the practice had improved the recording of the temperature of vaccine fridges. In addition to monitoring the fridge temperatures daily, a device to monitor the fridge temperatures over a 24-hour period had been purchased and was being used. The data from this device was downloaded weekly to check that fridges were operating effectively.
- No controlled drugs were stored on the premises.

Track record on safety and lessons learned and improvements made

Significant events	Y/N
There was a system for recording and acting on significant events	Y
Staff understood how to report incidents both internally and externally	Y
There was evidence of learning and dissemination of information	Y
Number of events recorded in last 12 months.	17
Number of events that required action.	17

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

Event	Specific action taken
Fridge door had been left open overnight.	All vaccines were checked, disposed of or kept according to manufacturer's instructions. The fridge was levelled to prevent the door from accidently opening.
Pathology samples not collected on two occasions.	The practice reviewed where samples were kept. Collection point was moved to ensure samples were visible when they were collected.
Patient summary found outside a school.	All clinicians had been reminded to have systems in place to ensure patient information taken outside the surgery, was returned/shredded. The Information Governance officer was notified for advice.

Safety Alerts	Y/N
There was a system for recording and acting on safety alerts	Y
Staff understand how to deal with alerts	Y

Comments on systems in place:

A new way of recording alerts had been adopted since March 2018. Spreadsheets record date of alert, action taken and completed dates. Relevant documents were embedded into the spreadsheets. These were then checked at the monthly health and safety meeting to ensure all appropriate actions have been taken. The practice manager demonstrated they kept oversight of outstanding actions.

Any additional evidence

In May 2018 a new system of meetings was implemented including separate meetings for clinical issues, partners, safeguarding, and health and safety/information governance. These were to replace the weekly all-encompassing practice meetings which had become too busy and ineffective.

A member of staff drafted minutes of meetings and these were seen stored on the practice's computer system where all relevant staff had access. Staff were notified when the minutes were available to be read.

Effective

Effective needs assessment, care and treatment

Prescribing				
Indicator	**Practice performance**	**CCG average**	**England average**	**England comparison**
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2017 to 31/03/2018) (NHSBSA)	1.48	0.93	0.84	Comparable with other practices

People with long-term conditions

Diabetes Indicators				
Indicator	**Practice performance**	**CCG average**	**England average**	**England comparison**
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	74.9%	82.1%	79.5%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	25.1% (88)	16.8%	12.4%	
Indicator	**Practice performance**	**CCG average**	**England average**	**England comparison**
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2016 to 31/03/2017) (QOF)	76.1%	79.9%	78.1%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	21.4% (75)	12.8%	9.3%	

Indicator	Practice performance	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2016 to 31/03/2017) (QOF)	72.0%	81.0%	80.1%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	21.7% (76)	17.8%	13.3%	

Other long term conditions				
Indicator	**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, NICE 2011 menu ID: NM23 (01/04/2016 to 31/03/2017) (QOF)	80.7%	76.5%	76.4%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	24.2% (104)	9.3%	7.7%	
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
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 (01/04/2016 to 31/03/2017) (QOF)	92.6%	93.3%	90.4%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	27.7% (31)	13.4%	11.4%	

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2016 to 31/03/2017) (QOF)	86.1%	84.8%	83.4%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	14.3% (131)	4.7%	4.0%	

Indicator	Practice	CCG average	England average	England 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 (01/04/2016 to 31/03/2017) (QOF)	94.4%	91.1%	88.4%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	7.2% (7)	7.8%	8.2%	

Any additional evidence or comments

We reviewed the practice performance in relation to Quality Outcomes Framework (QOF) for the year ending March 2018 as well as their current performance. QOF is a system intended to improve the quality of general practice and reward good practice. Data from the practice which was unverified showed:

The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) was 66% which was lower than the 2016/17 data. Exception reporting was 7.85% which was lower than the previous year of 25.1%. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. The practice's current performance as at 25 September 2018 was 66%. This showed the practice was on track to improve their performance from the previous year.

The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) was 59% which was lower than the 2016/17 data. Exception reporting was 5.89% which was lower than the previous year of 21.4%. The practice's current performance as at 25 September 2018 was 61%. This showed the practice was on track to improve their performance from the previous year.

The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) was 65% which was lower than the 2016/17 data. Exception reporting was 8.13% which was lower than the

previous year of 21.7%. The practice's current performance as at 25 September 2018 was 70%. This showed the practice was on track to improve their performance from the previous year.

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, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) was 74.2% which was lower than the 2016/17 data. Exception was 2.16% which was lower than the previous year of 24.2%. The practice's current performance as at 25 September 2018 was 73%. This showed that the practice was on track to improve their performance from the previous year.

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 (01/04/2017 to 31/03/2018) was 85% which was lower than the 2016/17 data. Exception rate was 15.9% which was lower than the previous year of 27.7%. The practice's current performance as at 25 September 2018 was 79%. This showed that the practice was on track to improve their performance from the previous year.

The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) was 74% which was lower than the 2016/17 data. Exception was 3.16% which was lower than the previous year of 14.3%. The practice's current performance as at 25 September 2018 was 75.2%. This showed the practice was on track to improve their performance from the previous year.

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 (01/04/2017 to 31/03/2018) was 96% which was better than the 2016/17 data. Exception reporting was 3% which was lower than the previous year of 7.2%. The practice's current performance as at 25 September 2018 was 96.9%. This showed the practice was on track to improve their performance from the previous year.

The practice explained there had been staffing issues which impacted on reviews of long term conditions. There was now a lead GP who has oversight of diabetes review. Since the last inspection, the practice had recruited another nurse who was undertaking training in the management of diabetes. The practice held regular clinical meetings monthly and QoF performance was reviewed and clinical staff was updated on current performance and any further actions required. Staff we spoke with demonstrated a better understanding of the improvements the practice was driving to improve reviews of long term conditions.

We reviewed patient records which demonstrated patients were invited for reviews and where they had been excepted, there was rationale for the decision not to undertake a clinical review. Exceptions and exclusion was now undertaken by a GP after reviewing the patient's condition. Nurses told us that in additional to patients being sent three letters to invite them to attend a review of their long-term condition, were now sent text message to the patient or telephoned them to encourage them to attend a review.

Following staff training from the Gloucestershire Domestic Abuse Support Service, the practice was now identified as a Safe Space Surgery. This meant the practice was a place where it was easier for victims of abuse to seek confidential help. Information posters and leaflets were on display in all waiting rooms and a support video was played on the waiting room television screens. There were also confidential support request cards available where patients can alert staff that they need help. Additionally, two members of staff had undergone additional training to become Domestic Abuse Champions.

The practice told us they were continually trying to identify carers amongst the practice population. New patients were asked in the patient questionnaire and clinicians were reminded to ask patients if they had caring responsibilities. Any new carer identified was sent a Carer's Pack informing of their entitlement to an annual health check and free flu vaccine. This also encouraged them to contact Gloucestershire carers for further support. In July 2018, the practice celebrated the NHS 70th Birthday with a "70T party" on the terrace outside. Gloucestershire Carers were invited to come and meet the patients and £270 was raised for Cheltenham & Gloucester Hospitals. Eighty-two patients had been identified as carers compared to 73 at the last inspection in November 2017. This represented 1% of the practice population. The practice population had also increased from approximately 7,300 to 7,600 patients.

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 comparable, 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 comparable 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 Band	Z-score threshold
1	Significant variation (positive)	Z ≤-3
2	Variation (positive)	-3 < Z ≤ -2
3	Comparable to other practices	-2 < Z < 2
4	Variation (negative)	2 ≤ Z < 3
5	Significant variation (negative)	Z ≥3
6	No data	Null

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.

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:

http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease
- **PHE**: Public Health England
- **QOF**: Quality and Outcomes Framework (see https://qof.digital.nhs.uk/).
- **RCP**: Royal College of Physicians.
- **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.(See NHS Choices for more details).