Care Quality Commission

Inspection Evidence Table

Kirby Road Surgery (1-539233144)

Inspection date: 29 January 2020

Date of data download: 23 January 2020

Overall rating: Requires Improvement

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Well-led Rating: Inadequate

At the inspection in September 2019 we rated the practice as inadequate for providing well-led services because:

- There were flaws in the leadership and governance of the practice.
- Staff were not supported fully by the GP partners.
- Systems and processes in place were not adequately followed.
- A fire risk assessment had not been completed to support decisions made in relation to fire alarm checks.
- Essential risk assessments had not been completed in relation to security and, health and safety.
- There was a lack of staff meetings and formal communications with staff. Outcomes and learning from significant events and complaints were not shared with practice staff.

At the inspection in January 2020 we found improvements had been made. The practice had taken the action needed to comply with the legal requirements of the warning notice we issued.

Leadership capacity and capability

Leaders could 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.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
Explanation of any answers and additional evidence: Following the September 2019 inspection, • The practice developed an action plan to make improvements to the practice. Tasks had been identified with a nominated staff member who was responsible for completion and dates for when	

they should be actioned by.

- The two practice managers had shared knowledge of their individual roles with each other so they could work independently if one was not working in the practice. Both practice managers had an oversight of risk assessments and staff training that had been completed.
- Practice meetings and communication channels via e-mail had been put in place to support staff and keep them updated with any changes taking place.

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:
Following the September 2019 inspection,

- We were informed that all staff were aware of the policies and procedures in place to govern the practice.
- Policies relating to the monitoring of patients who were prescribed high risk medicines had been reviewed and updated. These were available to all staff on the practice computer system. Records we reviewed showed that blood test results were recorded in the patient computer record by the GPs prior to issuing a prescription.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/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.	Y

Explanation of any answers and additional evidence:
Following the September 2019 inspection,

- A programme of appraisals was put in place. The practice managers had completed or had a date planned for appraisals for all staff. There had been no plans in place for the practice managers appraisals.
- An audit had been undertaken to look at the appropriate prescribing and monitoring of anti-coagulation therapy. The findings of this audit had been discussed at a clinical meeting.
- Risk assessments had been completed an identified action taken. For example,
    - A health and safety risk assessment had been completed on 8 October 2019. Anti-slip hazard tape had been placed on the raised wood in the doorways. The mercury sphygmomanometer had been removed from the practice. Health and Safety Executive posters were displayed in the staff room and reception office.
    - A security risk assessment had been completed on 8 October 2019. A new lockable door had been fitted to the reception office. Staff had been issued with lanyards to keep their SMART cards securely with them at all times. All staff had completed information governance training.
    - A fire risk assessment was completed on 8 October 2019. Emergency lighting had been installed to the rear exit of the building. Waste bins had been removed from the porch area to reduce fire risk. A log book was in place to record all actions taken in relation to fire safety including emergency lighting checks and fire drills. A fire drill had been completed in November 2019.

Continuous improvement and innovation

There were 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:
Following the September 2019 inspection,

- Practice meetings had taken place where information was shared with staff members. Minutes of the meetings showed that discussions had taken place regarding recent complaints and actions taken following the inspection.
- The communication book that had been in place was no longer used. E-mail communications were in place.

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)	≤-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.