Unofficial guide to getting a...

CQC outstanding rating

- I was a salaried GP when the dreaded CQC inspection team came to us in 2018.
- We were rated 'Good' in all areas. I think we can do better.
- I want us to be like a slickly oiled machine, everything flowing smoothly.
- Like the tiny cogs in a watch, all inter locked and working in unison.
- Like the theatre team performing an 8 hr operation on a congenital heart defect in a 1 week old baby at Great Ormand Street Hospital.
- Like the pit stop crew in a formula one race in Silverstone.
- Like the NASA technicians at Houston when they are preparing a space flight launch.
- Everyone doing their bit to accomplish a greater goal.
- But to develop such a system where each staff member knows what to do and what others do, you need to ask a million questions.
- You (the leaders in the practice) have to be curious.
- You have to stick your nose into other people's business.
- And when they say, 'This is how it is', you have to reply, 'Say's who?'
- Trust me. We all think the same thing about the CQC. But just play the game once in 5 yrs.
- And remember, they want physical evidence of every single thing you claim. So start to keep a record from now !
- Patient record numbers and dates of a consult which shows whatever you want to highlight
- Policies, letters of compliments, emails from you liasing with other health careprofessionals etc.
- I've made this chart based on an article about CQC from a journal, and also from reading reports from the CQC website for outstanding GP practices.
- You can't do everything I've listed. No one can. Just do your best.

Disclaimer:
Read the disclaimer at medimaps.co.uk/disclaimer

References:
1. Independent Nurse journal, Oct 2018
2. cqc.org.uk

SAFE

Significant events
- We have an open, transparent and blame free culture when significant events occur.
- We hold a monthly meeting for significant events
- The meeting is attended by the significant event and quality assurance lead.
- At least one person from each team is there e.g. dr, nurse, HCA, reception etc.
- That way the feedback is circulated through the entire team.
- The minutes of the meeting are then shared with all relevant staff.
- We group the events into categorises e.g. communication, medication, confidentiality etc.
- This way it makes it easier to see if a specific area(s) are regularly causing issues.
- We share the learning points with those outside of our own practice (obviously anonymising the details).
- e.g. District nurses, local practices, the local LMC, or even the laboratory department in the hospital.

Learning disabilities (LD)
- Longer appointments for patients with a learning disability (LD).
- Have close links with the community LD nurse.
- Pt's with a LD should have a care plan in place, a medication and a face-to-face review in the past 12 months.
- We have a dedicated lead who performs these checks on a regular basis.

Register of vulnerable pt's
- Have a register of those living in vulnerable circumstances e.g. homeless, travellers and those with a learning disability.
- We advice them on how to access voluntary organisations and support in the community.
- Pt's with no fixed abode are able to register at the practice by recording their address as the local homeless shelter (with their agreement).

Interpretation service
- We have access to interpretation services.
- We also have dr's /nurses who can speak a 2nd language to more easily connect with the pt.
- The need to consider the need for an interpreter is highlighted on the pt record.

Spotting abuse
- Staff have had training for spotting signs of abuse in vulnerable adults and children.
- They know what actions to take if they have any concerns.

Carers health needs
- Carers of pt's have an annual health check, flu vaccination and a review of their stress levels.

Hard of hearing
- Hearing loop availble.
- Sign language support available.
- The need to consider, this is highlighted on the patient record.

Poor vision
- Patients who are blind and cannot see the calling screen are physically called by the nurse/dr.
- The need to do this is highlighted on the patient record and an additional note is added under the appointment slot.

Security
- Prescriptions are securely stored, and removed from printers each day.
- Doors are locked when not occupied for extended periods.

Fire safety
- Regular fire drills.

Legionella precautions
- Legionella precautions in place.

Locum staff
- Locum staff induction packs explain the policies.

EFFECTIVE

Annual review
- Have a structured annual review system.
- At the review we think, can other health care staff step in to help.
- And if so, refer the patient to them e.g. community COPD nurse, dementia café, podiatrist for foot care etc.
- The person doing the annual review knows about these services and how to access them.

Proactive screening
- There are a few commonly undiagnosed conditions. We are proactive in identifying them e.g. diabetes, COPD, hypertension.
- We use an Alive Cor device to screen for AF during flu clinics and during annual health checks.

Investment into equipment
- We have access to 12 lead ECG.
- 24 hr ambulatory BP monitoring.
- Portable defibrillator for GP's when they perform home visits.
- A blood glucose machine that also reads ketone levels.

Guidelines
- Staff have access to clinical guidelines to ensure delivery of high quality care.
- e.g. NICE CKS, GP notebook, local clinical guidance.

QOF leads
- There is a lead for each area of QOF to ensure a drive to meet the clinical criteria set out within that framework.
- The clinical exception reporting is within local and national averages.

Clinical audits
- Clinical audits were carried out and acted on.

Standardisation
- The clinical templates are up to date.
- They used by all the staff to ensure reduced variability.

Palliative template
- We have made a protocol on the computer system which helps automates a number of activities.
- It adds the pre-emptive medication to the record, prints it off, and a directive for the district nurses to administer.

Investigation planner
- We have made an investigation planner.
- This is a shortcut on the computer system which allows us to add a diary entry to the patients record so we will remember to action a blood test or DEXA scan for example.
- The diary entries are searched every month and actioned.

Deputising for colleagues
- We have a system of deputies set up on the patient records system.
- This prevents investigation results and tasks from being left unactioned if a doctor is off duty.

Resus drills
- Once every 2 months a practice drill is performed to simulate a resus situation.
- All staff are involved in the scenario.
- A debrief occurs afterwards.

Clinic letters
- All clinic letters are reviewed by a dr via the Docman system.

CARING

Donating to charity
- We donate to a local charity which carers for vulnerable people.
- e.g. Local homeless shelter, womens refuge, day centre etc.
- Staff ran at a local half marathon to raise money for the local hospice.

Set up a fund
- We have set up a fund to allow specific patients to get their transport fee paid.
- e.g. A mother comes to the surgery on the bus with a sick child and 2 other older children have to also come, as there is no one at home to look after them.
- A thunder storm starts. We can use the fund to pay for a taxi.
- We loan equipment to patients to save them the expense.
- e.g. Home BP machine for suspected hypertension.

RESPONSIVE

Investing in staff
- We have employed more salaried GP's to make sure we can meet the rising demands
- We have hired a third nurse to to cope with extra workload with the ageing population who have more complex chronic diseases.

Same day appointments
- Same day appointments are available for those with urgent problems.
- Appointments are monitored, and adjusted depending on demand and regularly audited to identify emerging patterns and themes.
- e.g. We offer more same day slots after bank holidays, during times of flu epidemics and winter pressures.

Learning disabilities (LD)
- Longer appointments for patients with a learning disability (LD).

Bringing clinics and services into the practice
- We offer shared care prescribing for substance misuse.
- A clinical pharmacist to provide medication reviews and run a minor ailments clinic.
- A weekly diabetic clinic.
- Anticoagulant clinic.
- Employed a permanent phlebotomist to free up the HCA's.
- A weekly mental health nurse clinic.
- USS service in house.

Female GP's
- Female GP's to allow patients who need a gynaecological examination the choice to have a female clinician.

Early/late appt
- Early and evening appointments to make it easier for those who work.

Appt booking options
- We allow patients to book appointments in different ways e.g. online, telephone, face to face.

Continuity of care
- We are usually able to offer the same dr to see the pt to allow continuity of care.

Home visits
- We offer home visits for those elderly patients who find it extremely difficult to get to the surgery.
- Pro actively arranging scheduled home visits for the elderly or those in nursing homes. Looking at daily living needs, falls risk, assessing the need for appliances and aids, and also fire hazards assessments.
- This is done using a notice board showing dates of the last visit and dates of upcoming scheduled follow up visits.
- The aim is to reduce the demand for appointments.
- We also triage requests for home visits to assess the need and urgency.
- If the situation is extremely urgent and the dr is in the middle of the clinic e.g. reception staff to tell pt to diall 999 or speak to the 111 service.

Travel vaccine
- Nurse led NHS travel vaccine scheme.
- We also ffer private vaccine services as well.

Physical access
- Disabled facilities, accessible for pushchairs, baby changing facilities and a notice displayed offered patient privacy for breast feeding.

Substance misuse
- Each pt has a care plan.
- Receive a meds review and a face to face review each year.

Complaints
- A designated responsible person who handles all complaints.
- Posters displayed in the reception area about how to complain.
- Leaflet available at reception.
- Copies are placed in the new patient registration pack.

Macmillan champion
- There is a Macmillan champion appointed who acts as a single point of access for pt's so they can be directed to the appropriate services to help with their issues.

Social media
- Social media is used to highlight health advice e.g. smoking cessation clinics available in the local area.
- Text messages to remind pt's of their appointments.

Online access
- Proactive in offering online services to book and cancel appointments, order repeat medication and access medical records online.

WELL LED

Standards of care
- Signed up to the National Institute for Health Research network.
- Signed up to the Clinical Practice Research Datalink (CPRD).

Duty of candour
- Staff are aware of the duty of candour requirement when things go wrong.

Structure
- A clear leadership structure.
- A clear staffing structure in place and staff are aware of their own roles and responsibilities.
- Where necessary deputies are appointed to cover key areas of work such as safeguarding and this adds resilience within the practice.
- Staff feel supported by management.

Patient participation group (PPG)
- Feedback from the PPG is obtained to understand the needs of the pt poppultions.
- There is a close link between the leadership and the PPG.

Staff feedback
- Regular team meetings.
- An open culture within the practice, and they havethe opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff feel respected, valued and supported.
- All staff are involved in discussions about how to run and develop the practice, and the partnership encourages all members of staff to identify opportunities to improve the service delivered by the practice.
- e.g. adjusting nurse led appointments slots to allow enough time for them to complete a full COPD review etc.

Audits
- Regular audits of clinical and non clinical metrics, with appropriate actioning of findings where needed.

Training clinical staff
- Teaching placements for medical students from the local university.
- Training of FY2's.
- Training GP registrars.
- Placements for nursing students.
- School work placements.
- There are trained supervisors for these trainees.
- When the supervisor is not working other members of staff are available to provide training and supervision.

Training non-clinical staff
- Safeguarding and basic life support training arranged for all staff.
- Either face to face or online training modules.

Educational meetings
- Local consultants are invited to give a lecture on a specific topic.
- These are sponsored by drug representatives but they have no input into the clinical meeting.

Policy access
- Practice specific policies are available to all staff on the shared computer drive.
- These are regularly reviewed and updated.

Performance
- The local population needs and our performance to meet these are constantly reviewed.
- Using tools such as QOF performance, local CCG data and Primary Care Web Tool data.

Staffing levels
- We ensure there is a minimum number of dr's on duty to allow safe running of the practice.
- There are always 2 dr's on duty throughout the day.

Reminder presentations
- We have a regularly updated powerpoint presentation which summarises the main policies and actions that are expected of clinicians.
- This is required viewing at least once a month.

Whatsapp group
- We have 2 whatsapp groups set up.
- One for salaried and partners.
- And another for all clinical staff including nurses and HCA's and the deputy manager.
- The manager is in both groups to ensure it is use appropriately.
- No confidential information is shared.

Morning huddles
- Each morning all the practice staff meet up in the morning before the start of the day.
- We go through a checklist of questions.
- This includes checking staffing levels and who is the supervisor for the training dr's.
- Also if any important events occurred the day before, or anything that needs to be brought to attention of staff.
- This has highlighted a number of issues over the years we have been running this, and everyone participates.

OLDER PTS

Older people
- Proactive, personalised care.
- A named GP.
- A regular assessment and review for those on regular medication.

Services in the community
- Services such as the anticoagulation clinic make it easier for older pt's to access vital medical treatment.
- Others include ultrasound scans etc.
- We also liase with the local Integrated Care Pathway (ICT) team who provide IV treatment for infections, or DVT.
- We access the expertise of the Rapid Response team for pt's who are often elderly and need more support than can be offered solely by the primary care team e.g. chest infection which may need same day blood tests and IV antibiotics.

Home visits
- Older pt's often find significant difficulty attending the practice due to a variety of reasons (e.g. poor mobility, pain, lack of transport).
- For these pt's we perform home visits.

Safe and well checks
- We work with the local fire service to direct older pt's to the home assessment check that is performed by the local fire service.
- They assess fire risks and action any potential harms that are present.

CHRONIC DX

Chronic disease
- The nursing team have the lead role in managing pt's with long term disease e.g. asthma, COPD, diabetes.
- There are extended chronic disease management clinics which allow the nurses enough time to perform the vital checks.
- If needed these appointment can be extended if the patient has particularly complex needs. These situations are highlighted on the pt record so the reception staff can book enough time.
- Where possible multiple conditions are assessed at the same time to avoid as much as possible repeat visits to the surgery.

MDT meetings
- We arrange a MDT meeting once a month to discuss pt's with more complex medical needs. This enable joined up and holistic care and all parties are kept up to date with the status of the pt.
- This allows team members from various primary care teams to input their assessment outcomes e.g.community matron, COPD nurse, palliative care nurse, social worker, housing representative,
- e.g. A pt with COPD who is housebound. The community COPD nurse can do a home visit to ensure they are on optimal management. If she highlights care issues the social worker can then agree to start the assessment process. And the palliative care nurse can remind staff to consider the end of life needs if they become more unwell.

Expert patient programme
- We encourage pt's with long term conditions to attend the expert pt programme.
- This supports pt's by increasing their knowledge and confidence, improving quality of life and helping them to manage their condition more effectively.

FAMILY KIDS

Safeguarding
- There are systems in place to identify and follow up children living in disadvantaged circumstances and who are at risk.
- e.g. Children and young people who have a high number of A&E attendances.
- We identify and code children who fail to attend a practice or hospital appointment, to detect any safeguarding concerns.
- If there are any concerns we discuss with the child safeguarding lead in the practice who can then advice of the need to get other professionals involved e.g. health visitor, school nurse etc.

Immunisations
- All staff encourage parents to immunise children.
- We have developed a policy of informing the health visitor of any children who do not attend for their immunisations.
- The health visitors can build strong ties with families and it is hoped they can use their relationship to encourage uptake of immunisations.

Appointment availability
- Appointments were available outside of school time to allow them to attend without missing school lessons.

Family planning services
- A full range of family planning services are provided.
- e.g. Free condoms, fitting of contraceptive implants and intrauterine devices.

Cervical screening
- One of the nurses promoted the uptake of cervical smears.
- She organised a sponsored run to rais money for the charity.
- All staff were wearing pink T-shirts to promote screening over a 4 week period.
- All clinical staff were reminded to ask pt's to book in for the smear if the pop up alert appeared on the screen while in the pt's record.

WORKING

Appointment availability
- Early morning appointments are available on Wed mornings each week.
- This can be with a nurse or a doctor.
- If this is still not convenient we can arrange a telephone consultation.

Online access
- We encourage online access, which makes it much easier for pt's to book or cancel appointments, request medication or look at their test results.

Social media
- We use social media to push out key health care messages.

Wellman/women checks
- Pt's can access a wide range of health promotion initiatives from the practice e.g. smoking cessation clinic, weight management, stress management/counselling etc.
- We offer a screening health check to detect undiagnosed health needs e.g. hypertension, diabetes.

National screening
- We wrote or called pt's who had declined the national bowel screening invitation.
- There is evidence that engagement from the primary care team can make pt's accept the invitation.

VULNERABLE

Identifying vulnerable pt's
- We maintain registers of pt's who are vulnerable.
- e.g. Learning disabilities, mental health disorders, travellers, domestic abuse, child protection register.

Screening uptake
- We work with the local cancer screening outreach nurse to offer breast and cervical cancer screening for those pt's with a LD.

Service personnel
- Ex-military personnel receive priority referrals to secondary/primary care services as it is recognised that their condition could be related to past service.
- We add a pop up warning to their records as well as a code to highlight this.

Domestic abuse liason
- We are part of a pilot in which we have a dedicated single point of contact for anyone we are concerned about in terms of domestic abuse.
- The liaison officer then makes an appointment to see the pt at our practice.
- We are encouraged to ask the questions that would bring this issue to light.
- And there is also a pop up screen message that appears when specific terms are typed into the pts record.
- We also have posters in the pt toilets so they can note down the contact details.

Alcohol screening
- We include an alcohol screening tool within the new pt registration pack.
- We also assess this during the annual review with pt's with chronic conditions and during a screening health check.

MENTAL HEALTH

Annual health check
- Pt's with dementia and severe mental health disorders have an annual face to face health check.
- This allows us to do a medication review, and assess health status and any unmet health needs.

Mental health nurse
- The primary care mental health nurse holds a weekly clinic at the practice.
- We are able to direct pt's to these appt's.
- We work closely with the nurse who can speak to us face to face or via the computer system messaging service.

Appointments
- When an appointment is booked in the future we add a note under the appointment slot that they have dementia.
- This allows the staff to ring the pt on the day to remind them of their appointment.