

Care Quality Commission

Inspection Evidence Table

Westwood Clinic (1-537739816)

Inspection date: 13 August 2019

Date of data download: 12 August 2019

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Safe

Safety systems and processes

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y ¹
There was active and appropriate engagement in local safeguarding processes.	Partial ²
There were systems to identify vulnerable patients on record.	Y ¹
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial ²
Explanation of any answers and additional evidence: 1 – The practice had reviewed all patients on the safeguarding register and identified that the safeguarding concerns which were not recorded appropriately related to lower-level soft intelligence and not children with protection plans in place. The practice had held conversations with the Clinical Commissioning Group's technological implementation team regarding how these can be appropriately recorded in the future. 2 – At the previous inspection, we found the only attendees at multi-disciplinary meetings were practice staff and no other healthcare professionals attended to share information. At this inspection, the practice told us multi-disciplinary team meetings were attended by an external co-ordinator who would liaise with other services. The practice told us they were in communication with the district nursing teams about attending future meetings.	

Safety systems and records	Y/N/Partial
A fire risk assessment had been completed. Date of completion: January 2019	Y ¹
Actions from fire risk assessment were identified and completed.	Y ¹
<p>Explanation of any answers and additional evidence:</p> <p>1 – At our previous inspection we found the practice had completed a fire risk assessment; however, the accompanying action plan did not evidence the practice had complete oversight of the actions requiring completion and the progress of those actions.</p> <p>The practice had a visit from Cambridgeshire Fire & Rescue Service on 3 August 2019 and a review of the building fire safety arrangements and the previous risk assessment found the practice to be compliant.</p> <p>New weekly fire safety checks had been implemented by the practice manager and we saw evidence to show these had been started.</p>	

Information to deliver safe care and treatment

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	N ¹
<p>Explanation of any answers and additional evidence:</p> <p>1 – At the previous inspection we found the practice's system of coding clinical records was not always effective. We found one example of a six-year-old child who had been incorrectly coded as having a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). We found a member of the practice team had excepted this patient from COPD annual monitoring, rather than highlighting the incorrect coding.</p> <p>At this inspection we found the practice had not rectified this issue and the six-year-old child remained incorrectly coded as having a diagnosis of COPD. The practice advised they were continuing to work on their clinical coding and improvements should be made in this area.</p>	

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y ¹
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y ²
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 ¹
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y ⁴
<p>Explanation of any answers and additional evidence:</p> <p>1 – At the previous inspection we found a practice nurse was undertaking diabetic, COPD and asthma reviews. When reviewing consultation records of these reviews we found changes to prescribed medicines were made, however, this nurse was not a prescriber. There was no evidence on the consultation record of a clinical discussion with a GP to authorise the changes made. When we spoke with the practice nurse, she told us GPs would authorise the changes but there was an inconsistent approach in the practice.</p> <p>At this inspection we found the provider has reconfigured the practice nurse's smart card to remove the prescribing abilities. Where a patient required a medicine change, this was only to be completed by a GP who recorded it directly into the medical record. If no GPs were available at the time of the appointment, a second appointment with a GP would be booked.</p> <p>2 – The practice had reviewed medical records and found the coding for medicine reviews was not accurate. Therefore, the practice planned to review all patients on a repeat medicine and prioritised those over 75, under 5 and those diagnosed with a long-term condition. At the time of inspection, the practice had completed 470 of approximately 3,200 medicine reviews and the practice had held additional clinics during the week and at the weekends to support this.</p> <p>4 – At this inspection we found improvements to the high-risk drug monitoring from the previous inspection. However, where patients were reviewed elsewhere, signed shared care agreements were not on the patient records. Since our inspection, the practice had contacted secondary care and found that shared care agreements were no longer in place in this locality.</p>	

Track record on safety and lessons learned and improvements made

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y ¹
Staff understood how to deal with alerts.	Y ¹
<p>Explanation of any answers and additional evidence:</p> <p>1 – At the previous inspection, we found the practice’s system for managing and acting on safety alerts was not effective. At this inspection, we found the practice had made changes to this process and all safety alerts were distributed by the practice manager across the staff team. All safety alerts were then reviewed at clinical governance meetings.</p> <p>We found the practice had taken action for the most recent safety alerts and had also actioned historic safety alerts which had previously not been managed appropriately.</p>	

Effective

Effective needs assessment, care and treatment

Diabetes Indicators	Practice	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 (01/04/2017 to 31/03/2018) <small>(QOF)</small>	94.8%	80.5%	78.8%	Significant Variation (positive)
Exception rate (number of exceptions).	29.7% (97)	15.6%	13.2%	N/A
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) <small>(QOF)</small>	91.1%	74.3%	77.7%	Variation (positive)
Exception rate (number of exceptions).	24.5% (80)	11.8%	9.8%	N/A
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) <small>(QOF)</small>	87.6%	79.2%	80.1%	No statistical variation
Exception rate (number of exceptions).	33.6% (110)	15.4%	13.5%	N/A

Any additional evidence or comments

The practice had a higher exception reporting rate for diabetes indicators. At the previous inspection we found the practice were aware of this; however, they had no plans to try to reduce the number of exceptions made. We reviewed submitted but unverified exception reporting data for 2018/2019 and found this high level of exception reporting had been sustained.

At this inspection we found the practice had taken a new approach to exception reporting and put in place a system where each exception must first be reviewed by the practice manager and lead GP. During the four-week suspension period, no exception codes had been added to patient records. However, due to the lack of available data, improvements in this area will need to be reviewed at the next inspection.

Cancer Indicators	Practice	CCG average	England average	England comparison
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) (01/04/2017 to 31/03/2018) (Public Health England)	65.3%	N/A	N/A	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	68.3%	73.4%	69.9%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	41.5%	57.0%	54.4%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	20.0%	63.0%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	76.9%	60.6%	51.9%	No statistical variation

Any additional evidence or comments

The number of patients screened for cervical cancer was lower than both the CCG and England averages. The practice were aware of this as we raised this as a concern previously, but at the time of the previous inspection, the practice had no action plan in place to attempt to address this.

At this inspection we found the practice had started to engage with the CCG and had communication with the local lead for cancer screening. Additional posters and information materials were placed around the practice and on the practice website. The practice were planning educational talks with patients to encourage uptake.

However, due to the lack of available data, improvements in this area will need to be reviewed at the next inspection.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	94.4%	91.1%	89.5%	No statistical variation
Exception rate (number of exceptions).	33.3% (9)	13.3%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	100.0%	89.7%	90.0%	Variation (positive)
Exception rate (number of exceptions).	18.5% (5)	11.8%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	73.3%	85.0%	83.0%	No statistical variation
Exception rate (number of exceptions).	31.8% (7)	6.6%	6.6%	N/A

Any additional evidence or comments

The practice had a higher exception reporting rate for mental health indicators. At the previous inspection we found the practice were aware of this; however, they had no plans to try to reduce the number of exceptions made. We reviewed submitted but unverified exception reporting data for 2018/2019 and found this high level of exception reporting had been sustained.

At this inspection we found the practice had taken a new approach to exception reporting and put in place a system where each exception must first be reviewed by the practice manager and lead GP. During the four-week suspension period, no exception codes had been added to patient records. However, due to the lack of available data, improvements in this area will need to be reviewed at the next inspection.

Effective staffing

	Y/N/Partial
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial ¹
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial ¹
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial ¹
<p>Explanation of any answers and additional evidence:</p> <p>1 – At the previous inspection we reviewed clinical consultation records and found consultations were lacking in detail, were not of sufficient quality and therefore did not meet national guidelines. These records could not demonstrate patients seen by this member of staff received safe and effective care and treatment. The lead GP reviewed these consultations on the day of the inspection and agreed with the inspection team that these did not meet standards for record keeping. We asked for evidence of how the practice could demonstrate the competence of staff employed, and the practice were unable to do this.</p> <p>At this inspection we found the practice had started to implement a system of support and review for clinicians. After each clinical session, time was blocked out for the lead GP to support members of the clinical team. A formal action plan of support was implemented where appropriate and a traffic light system of prioritisation was used.</p> <p>We reviewed clinical records and found the record keeping had improved since the previous inspection.</p>	

Caring

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5335	361	91	25.2%	1.71%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2019 to 31/03/2019)	82.3%	90.0%	88.9%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	77.1%	88.0%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	89.9%	95.8%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	83.3%	84.4%	82.9%	No statistical variation

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Partial

Any additional evidence
<p>At the previous inspection we found the practice was aware of lower than average GP National Survey data. However, at the time of the inspection the practice did not provide evidence of any actions they had taken to improve the satisfaction of patients in relation to the care provided.</p> <p>Patients we spoke with on the day of the inspection provided negative feedback in relation to the attitude of some clinicians at the practice. Patients were positive in relation to the non-clinical staff at the practice but informed us that some clinicians did not always display the same caring attitude.</p> <p>Since that inspection, updated GP National Survey data had been released which evidenced significant improvements to patient satisfaction for caring indicators.</p> <p>At this inspection, the practice had started to commence a series of patient surveys to gauge patient satisfaction on the areas for improvement identified. The practice had a number of completed surveys and were in the process of collating the information to gather data and analyse trends. The practice told us this data would be used to form an action plan where necessary.</p>

Well-led

Continuous improvement and innovation

There was little evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial ¹
Explanation of any answers and additional evidence: 1 – At the previous inspection, we noted that several members of staff had completed a high volume of training in one day. For example, one member of staff had completed 20 modules of training in one day and according to the certificates, this amounted to over 24 hours of training and included safeguarding training. At this inspection we found the practice had reset all training for all staff on their online training system. This meant that staff were required to complete all training again. We reviewed training records and found the lead GP had started to complete their training in a more structured and timely manner. However, evidence was limited as not all staff had started to complete their training, therefore their training records appeared blank.	

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)	≤ -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.
- 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.

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>

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.