

# Care Quality Commission

## Inspection Evidence Table

### Westcotes GP Surgery (1-4056332034)

Inspection date: 3 February 2020

Date of data download: 30 January 2020

## Overall rating: Not rated

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

## Safe

## Rating: Not rated

### Safety systems and processes

**The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.**

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Y
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.	Y
Explanation of any answers and additional evidence: Following our October 2019 inspection, the practice took action to ensure staff had access to safeguarding policies and procedures. Inspectors viewed a random sample of care records which showed action had been taken to ensure safeguarding concerns discussed during multidisciplinary meetings were included in patients' clinical records.	

## Risks to patients

**There were adequate systems to assess, monitor and manage risks to patient safety.**

	Y/N/Partial
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 for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
Explanation of any answers and additional evidence: Members of the management team discussed arrangements' in place with a locum GP agency and explained clinicians were required to provide four weeks' notice which enabled the practice to arrange suitable locum cover.	

## Information to deliver safe care and treatment

### Staff had the information they needed 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.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Following our previous inspection, the provider contacted the local Clinical Commissioning Group (CCG) medicines management team and held discussions with clinical leads regarding systems for managing test result, providing non-clinicians with support and training around understanding the significance of blood results. In line with the provider action plan, the clinical team reviewed patient care records and took appropriate action to ensure results from blood tests carried out in secondary care were added to patients' clinical notes. Appropriate action had also been taken to ensure medicines dose were adjusted in response to blood results which were outside the normal range.</p> <p>Non-clinical staff who supported clinicians with the co-ordination of blood test results received support and training from the CCG medicines management team to enable them to carry out this function of their role safe and effectively. The provider had arranged for the development of a dashboard to support the monitoring of blood monitoring due dates and we saw evidence of clinical oversight to support the process. Non-clinical staff we spoke with demonstrated that they understood the significance of blood monitoring and described ongoing support from the clinical team. Staff explained the CCG medicines management team supported the practice to ensure dashboards used to support medicine management reflected national and local prescribing guidelines.</p> <p>The provider held meetings with local diabetes specialists to discuss the management of patient's conditions and took action to ensure disease registers were accurate; to ensure patients received appropriate care. The practice reviewed blood test results and patients with a result which indicated a diagnosis of diabetes as well as pre-diabetes were coded. Unverified and unpublished data provided by the practice showed the practice had identified a total of 118 patients; 40% were referred to a National Diabetes Programme and 100% received a repeated blood test. The practice had ongoing plans to ensure all patients were offered referral to national programmes. The provider recognised that actions to cleanse the disease register were ongoing and although we found records which still required appropriate read codes; the practice was moving in the right direction and working towards the providers timeframe for completing the actions required.</p> <p>Alerts were added to patient's problem list or summary such as information regarding patients' conditions to support the delivery of safe care and protect clinical staff from potential risk.</p>	

## Appropriate and safe use of medicines

### The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

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) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.46	0.79	0.87	Significant Variation (positive)
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). (01/10/2018 to 30/09/2019) (NHSBSA)	6.5%	8.1%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) (NHSBSA)	3.78	4.82	5.60	Tending towards variation (positive)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	2.59	2.18	2.08	No statistical variation

Medicines management	Y/N/Partial
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
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Explanation of any answers and additional evidence: Following our previous inspection, the provider held a series of clinical meetings with CCG clinical leads	

Medicines management	Y/N/Partial
<p>regarding high-risk medicine monitoring and developed an action plan in line with guidance received. Actions included introducing a new process which required GPs to review a summary of blood monitoring results and once they were satisfied with the findings a GP auto consultation clinical note template reflecting appropriate actions were then added to patients' clinical records. The provider also introduced an auto consultation template for health care assistants (HCA) which reflects discussions held with GPs. The management team explained that HCAs were booked onto anticoagulation monitoring (monitoring of patients prescribed a specific high-risk medicine) update review course relevant to their level of involvement in blood monitoring.</p> <p>Members of the management team including clinical leads explained non-clinical staff were no longer authorised to add 'medicine review done codes' to the clinical system or remove items from patients' medicines list. Staff explained a new system had been implemented where the management team carried out monthly searches and findings were sent to GPs. This would then enable GPs to check patients records and review or amend medicines accordingly.</p> <p>Actions carried out by the provider showed blood test results were being added to patients' clinical notes and clinical staff were able to demonstrate that they had reviewed results before authorising repeat medicines.</p> <p>Since our October 2019 inspection, the practice revisited risk assessments and their stock of emergency medicine. Inspectors found that the practice added additional emergency medicines to their stock; enabling staff to respond to a wider range of potential medical emergencies. The practice also reviewed and updated their risk assessment to mitigate potential risks.</p>	

**Track record on safety and lessons learned and improvements made**

**The practice learned and made improvements when things went wrong.**

Significant events	Y/N/Partial
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	Four
Number of events that required action:	Four
Explanation of any answers and additional evidence: Clinicians we spoke with demonstrated how they accessed significant events logs and demonstrated awareness of learning and actions taken when things went wrong. For example, staff were reminded of appropriate actions and who to inform if they detect that vaccination fridge temperatures went outside the recommended range.	

## Well-led

Rating: Not rated

### Leadership capacity and capability

**There was compassionate, inclusive and effective leadership at all levels.**

	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
Explanation of any answers and additional evidence: Following our October 2019 inspection, the provider had taken action to address the issues previously identified which impacted on their ability to achieve positive clinical outcomes, as well as deliver sustainable safe care and treatment. The provider developed an action plan demonstrating how the practice would become compliant with legal requirements. Staff we spoke with were knowledgeable about issues and actions required and explained they felt involved in the changes and lines of communication were clear.	

### 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: The provider accessed support from key stakeholders as well as specialists and leads in medicines management and long term conditions. The provider demonstrated that information and guidance received enabled them to review and strengthen the governance arrangements.  Inspectors found that there was a systematic approach to maintaining and improving the quality and effectiveness of patient care with clear clinical oversight. For example, the practice reviewed clinical records and took appropriate action to ensure information about patients care, treatment and their outcomes such as diagnosis and test results were accurately collected, added to patients records and monitored.  The clinical oversight of medicine management was strengthened, and we found non-clinical staff received training and ongoing support in their role which involved supporting clinicians. Staff we spoke with demonstrated awareness of how to access local and national prescribing guidelines. Clinical records we viewed showed the practice was operating in accordance to legislation which required a qualified prescriber to authorise and prescribe high-risk medicines.  There were clear roles and responsibilities and systems to monitor progress with the practices action plan. Quality, performance and risks were identified, understood and managed.	

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
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
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<p>Clinical records viewed by the inspection team provided assurance that accurate and up to date information about clinical effectiveness was being used or understood by staff. Staff were able to demonstrate that information was used following our previous inspection, to improve care and treatment. For example, issues picked up by the inspection team in areas such as medicine management as well as the management of long-term conditions were being addressed and there were ongoing actions which were being monitored by the management team.</p> <p>The management team demonstrated a systematic approach which enabled the practice to address areas where quality and safety was being compromised and to respond appropriately without delay. For example, the provider reviewed processes and provided staff with training to ensure blood review dates were recorded on the practice blood monitoring monthly validation form by non-clinical staff and were in line with national prescribing guidelines. Clinical records showed patients with blood results which should have prompted the practice to review management plans had been actioned and patients were contacted.</p> <p>The provider explained non-clinical staff were no longer adding 'medicine review done' codes to patient records.</p> <p>The provider reviewed the stock of emergency medicines and added additional medicines to enable the practice to respond to a wider range of medical emergencies.</p>	

## Appropriate and accurate information

**There was a demonstrated commitment to using data and information proactively to drive and support decision making.**

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y



There were effective arrangements for identifying, managing and mitigating risks.	Y
Explanation of any answers and additional evidence: Records viewed by the inspection team showed that information was accurate, valid and reliable and enabled the practice to effectively manage patients' conditions and ensure positive outcomes were achieved. The management team demonstrated a coherent approach to establish who held responsibility for monitoring QOF performance as well overseeing clinical activities within the practice.	

### Continuous improvement and innovation

**There were evidence of 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: Oversight of systems for managing significant events showed that these were investigated and responded to in a timely manner. Meeting minutes showed evidence of shared learning.  Actions taken following our previous inspection, were ongoing; however, the provider and management team demonstrated a strong focus on continuous learning as well as working proactively with stakeholders and clinical leads to strengthen the practice and deliver safe and effective care.	

## 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.