

Care Quality Commission

Inspection Evidence Table

Oldfield Surgery (1-569083319)

Inspection date: 17 January 2023

Date of data download: 07 February 2023

Overall rating: Requires improvement

Following our previous inspection in August 2022, the practice was rated as Requires Improvement overall.

We undertook a desk-based review on 17 January 2023 to follow up on the Warning Notice served to the provider following our inspection in August 2022 in relation to a breach of Regulation 12: Safe care and treatment. We have not rated the practice at this desk-based review as this will be revised at a later date through inspection.

During this review, we found the provider had made improvements in relation to embedding medicine management processes. In particular, ensuring safe care and treatment of patients with long-term conditions and patients prescribed high-risk medicines in line with national guidelines.

Safe

Rating: Inspected but not rated

At our previous inspection in August 2022, we found there were shortfalls regarding medicines management which led to the issuing of a Warning Notice of regulation 12: Safe care and treatment. In particular:

- The practice was unable to demonstrate appropriate monitoring of patients prescribed high-risk medicines was being carried out consistently when prescribing.
- The process for managing safety alerts was not being followed appropriately to ensure patients were protected from harm.
- Incoming outstanding abnormal patient results were not always reviewed and supervised by a clinical lead to ensure safety-netting.

At this review, the practice had demonstrated improvements to the management of patients prescribed high-risk medicines, with an action plan of patients who had undertaken the appropriate monitoring and medicine reviews. The practice had updated medicine management processes with guidelines for staff regarding clinical search audits as a safety mechanism for ensuring eligible patients were invited for appropriately timed reviews. We found the practice had improved the processes to ensure patients who

were affected by safety alerts were identified and managed appropriately for subsequent safe care and treatment.

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 were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	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> <ul style="list-style-type: none"> We conducted a clinical records search and found that reviews of patient records were managed in a way to protect patients. We reviewed five patient records to check the quality of medicine reviews and found that four of the five had the appropriate monitoring and medicine reviews in place with documented management plans within the patient record. However, we identified that not all medicines were linked with the diagnosis within the records which was updated by the practice after the inspection. We found that in one of the five records reviewed that an asthma patient had been consistently prescribed aspirin, a non-steroidal anti-inflammatory drug (NSAID) used to relieve pain and reduce inflammation, without a recent asthma check, which has shown to increase the risk of exacerbation of asthma symptoms as per national guidelines. After the inspection, the provider had reviewed this patient to ensure safe care and treatment was provided. The process for prescribing NSAIDs for asthma patients was updated, with an action plan in place to ensure patients will have a thorough medication review as part of their annual asthma review to determine whether any exacerbations could be linked to NSAID usage. Appropriate alternative medicines offered where the medicine is clinically recognised to have precipitated bronchospasm (tightening of the airways in the lungs). The reviewed process established the requirement for asthma patients who had been prescribed NSAIDs for the first time, to have the appropriate safety netting and planned follow-up, after a course of these medicines. At the previous inspection in August 2022, we identified abnormal patient results were not always followed up in a timely way to ensure safe care and treatment was provided. For example, there was evidence that the task management system did not reflect patient results were followed up for review on the same day by the cover clinician where there were absences in clinical staff. At this review, although not a specific focus for the inspection, the practice was able to demonstrate improvements had already been made in response to the Requirement Notice issued. For example, there was a documented approach to the management of test results. The practice had a 'buddy' system to cover clinician absences for outstanding patient results. The practice had implemented an action plan to ensure the 'duty' clinical lead (GP), provided clinical 	

oversight so that abnormal patient results were followed up and patients received safe care and treatment in a timely way.

Appropriate and safe use of medicines

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

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHS Business Service Authority - NHSBSA)	0.67	0.75	0.82	No statistical variation
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). (01/10/2021 to 30/09/2022) (NHSBSA)	11.4%	9.7%	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 (01/04/2022 to 30/09/2022) (NHSBSA)	4.97	4.82	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	145.2‰	122.4‰	129.6‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHSBSA)	0.94	0.61	0.58	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	7.7‰	5.7‰	6.7‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y

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
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Y
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
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At the previous inspection in August 2022, we found there were shortfalls in medicine management which included: There was a lack of safety netting to identify outstanding monitoring and a risk that patients who were prescribed high-risk medicines did not receive safe care and treatment in relation to the appropriate monitoring and clinical review prior to prescribing. In particular, patients prescribed Angiotensin-converting enzyme (ACE) inhibitors or Angiotensin II receptor blockers (A2RB), medicines used to treat high blood pressure. As well as patients prescribed potassium sparing diuretics, medicines used to treat high blood pressure or congestive heart failure. Clinical supervision was given by the practice's lead GP, providing oversight of performance and nurse prescribing was within scope of practice to ensure safe care and treatment. Informal conversations were completed at regular intervals, but records were not comprehensive to minute these discussions. During this review undertaken in January 2023, we found: We undertook remote searches of the practice's clinical patient records system. We identified improvements had been made to the monitoring of patients prescribed high-risk medicines to ensure safe care and treatment was provided. The practice had worked through the backlog of patients who were prescribed ACE or A2RB medicines and patients who were prescribed potassium sparing diuretic medicines, to ensure blood monitoring was up to date and in line with National Institute for Health and Care Excellence (NICE) recommendations. We saw evidence that provided assurances for patients who were prescribed non-steroidal anti-inflammatory drugs (NSAIDs) had the appropriate safety measures in place for the co-prescribing of proton-pump inhibitors (PPI), medicines to prevent gastric acid secretion and the protection of stomach ulcers. Safety alerts were raised on patient clinical records when NSAIDs were prescribed, for patients aged 65 and over, in line with national guidelines. The practice had a system in place for completing searches for patients prescribed this combination of medicines. Although not a specific focus for this review, the practice was able to demonstrate improvements had already been made in response to our requirement notice. We found clinical supervision records for non-medical prescribers were now up to date and there was a plan in place for regular meetings to be minuted. 	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At the previous inspection in August 2022, we found the provider was unable to evidence there was an effective system to ensure safety alerts were acted upon in a safe way to patients. One example were, actions taken in response to a safety alert regarding the patients who were prescribed the combination of Clopidogrel, a medicine used to prevent blood clots, and Omeprazole or Esomeprazole, medicines used to treat acid reflux or protect against stomach ulcers. All of the patients were found not to have been informed of the risks associated within the safety alert and had continued to have been prescribed in combination. During this review undertaken in January 2023, we found the management of safety alerts had been embedded and patients affected by safety alerts were managed appropriately. 	

Effective

Rating: Inspected but not rated

At our previous inspection in August 2022, we found the systems and processes in place for monitoring patients with long-term conditions had not been embedded in line with evidence-based guidance. The practice had not met the minimum NHSE target of cervical cancer screening uptake for eligible patients.

During this desk-based review, we found improvements had been made to the management of patient treatment plans, including the on-going monitoring in line with national guidelines. The practice was continuing to work towards the action plan of improving uptake for cervical cancer screening for eligible patients.

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

Effective needs assessment, care and treatment

Patients' needs were assessed, care and treatment was not always delivered in line with current guidelines. Evidence-based recommendations was used to support improvements to pathways and protocols.

	Y/N/Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">At the previous inspection in August 2022, we found the practice did not always use recognised clinical templates effectively to ensure best practice guidelines were always followed. For example, 12 patients were identified as having a potentially missed diagnosis of diabetes due to shortfalls in coding these correctly.At this assessment in January 2023, we saw improvements had been made to the approach to identify patients who required monitoring upon routine clinical searches. For example, through the management of patients with pre-diabetes and patients with diabetic retinopathy (a complication of diabetes, caused by high blood sugar levels damaging the back of the eye).However, patients with asthma were not always reviewed to ensure their treatment was optimised in line with national guidance. We found 131 patients with asthma who had been	

prescribed two or more rescue steroids in the last 12 months, without a 1-week follow-up upon presenting with acute exacerbations of asthma. This was advised to be completed by primary care providers by the 2014 National Asthma Audit and subsequent National Institute of Care Excellence (NICE) guidelines. We reviewed 5 patients and found 4 out of the 5 did not have the appropriate follow-up asthma review. There was evidence of improper coding for patients issued rescue steroids who presented with exacerbation symptoms. After our review, the practice implemented an action plan to improve the process to ensure safe care and treatment was given for these patients. Improvements included:

- Asthma clinics were delivered by advanced nurse practitioners (ANPs) and had dedicated appointment slots to manage patients, which included an asthma review, treatment plan and the issue of steroid card if appropriate (the NHS steroid emergency card is a prompt to help healthcare staff with information on emergency treatment).
- The practice's pharmacist team had reviewed all patients who had received rescue steroids on repeat prescription to ensure these were removed safely. Audits were completed at monthly intervals to check this process was adhered to and establish any further improvements and training needs.
- Patients were advised to report any acute exacerbations when rescue steroids were prescribed. The clinical system had a safety net mechanism so that these patients were flagged, to be booked for a follow-up asthma review appointment. Housebound patients had this provided via a telephone call conducted by an ANP.
- The practice had developed a new asthma management policy which gave guidance to clinicians for effective coding to improve patient care.

Effective care for the practice population

Management of people with long term conditions

Findings

- At the previous inspection in August 2022, we found patients with long-term conditions were not always offered a structured annual review to check their health and medicines needs were being met. We identified issues with patient medicine reviews and the process for outstanding monitoring of long-term conditions.
- During this review in January 2023, we found improvements had been made to the systems and processes for managing patients with long-term conditions who required on-going monitoring. For example:
- We identified patients with hypothyroidism, a condition which results in low activity of the thyroid gland, had the appropriate thyroid function (TFT/TSH) blood monitoring with the last 18 months. There were recall processes in place to ensure patients were followed-up with reminder letters and communications sent to patients as per the providers' clinical standard operating procedures.
- We identified patients with chronic kidney disease (CKD) stage 3, 4 or 5 had the appropriate blood monitoring and blood pressure recorded within the last nine months. There were examples of patients who were reviewed within secondary care, the practice clinical team worked with other health and care professionals to deliver a co-ordinated package of care.

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Cancer Indicators	Practice	SICBL average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 30/06/2022) (UK Health and Security Agency)	69.1%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	65.8%	67.4%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	65.0%	70.0%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	58.1%	59.5%	54.9%	No statistical variation

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Any additional evidence or comments
<ul style="list-style-type: none"> At the previous inspection in August 2022, we identified that the practice did not meet the minimum 80% target of eligible patient uptake of cervical screening. There was a delay to the national accreditation training for nurses to complete cervical screening competency. Although the practice's cervical screening results did not form part of its enforcement action, a recommendation to improve uptake was made. At this review, we found the practice had an action plan to improve uptake in this area and combined female health appointments with other acute or routine patient needs where possible. This was despite the latest verified data from the UK Health and Security Agency available, dated June 2022. We were presented with unverified, more up to date practice population cervical screening uptake data for eligible patients which showed 4,761 patients had completed a cervical smear out of 6,559 patients from April 2022 to January 2023. This showed a 72.6% uptake, meeting the minimum target. We will monitor and review this area at the next CQC inspection.

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. 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 SICBL 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 SICBL 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.
- **UKHSA:** UK Health and Security Agency.
- **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.
- **‰** = per thousand.