Care Quality Commission

Inspection Evidence Table

The Westgate Practice (1-553242073)

Inspection date: 01 October 2019 and 03 October 2019

Date of data download: 19 September 2019

Overall rating: Good

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

Safe Rating: Good

At our inspection in October 2018 we rated 'Safe' as 'Requires Improvement'. The practice was found in breach of Regulation 12 Safe Care and Treatment; specifically, assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. We issued a requirement notice in response to the breach.

At this inspection we found that the practice had met all the requirements of the requirement notice for regulation 12. Additionally, the practice had reviewed its management structure, increased the infection control team and made a significant number of improvements to the main building with a detailed plan of refurbishment and redecoration. There was a detailed plan to refurbish the branch at Shenstone and this had been widely publicised so that patients were aware that the branch would be temporarily closed for a couple of weeks.

At the October 2018 inspection we had made best practice recommendations in the following areas:

Improve the patient safety alert process. Improve clinical audit processes. Improve the consent process for minor surgery. Update the safeguarding policy. Review the investigative process for incidents and serious incidents. Review the auditory privacy in reception.

We found improvements had been made in all areas. However, ongoing actions and searches had not yet been included within the patient safety alert process.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes

Safeguarding	Y/N/Partial
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
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.	Yes
Explanation of any answers and additional evidence: The safeguarding policy had most of the required subjects within it and all of the areas within the appendix. Most vulnerable people were appropriately flagged in the system, we found one that had not been properly identified. This was corrected at the time of inspection. As health visitors no longer attended the multi-disciplinary safeguarding meetings, information of concern was shared with them for action and input as required. A flowchart illustrating the local safeguarding arrangements was available in all clinical rooms.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: August 2018 booked for November 2019	Yes
There was a record of equipment calibration. Date of last calibration: October 2018	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. All data sheets for COSHH substances which contained risk information were held centrally.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: March 2019	Yes
There was a log of fire drills. Date of last drill: January 2019 for main site and September 2019 for branch	Yes
There was a record of fire alarm checks. Date of last check: October 2019	Yes
There was a record of fire training for staff. Date of last training: Staff completed on a variety of dates throughout the year, and records maintained on central training log.	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: February 2019	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: The Shenstone branch had one fire marshal at the time of inspection, and the practice planned to train a second fire marshal to ensure that annual leave was covered. The main site had three trained fire marshals. The Shenstone branch had a complete log of all servicing information and all required checks had taken place within the last 12 months. The branch at Shenstone was about to change its water storage arrangements and new legionella testing was planned to follow this.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: September 2019	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: June 2019	Yes
Explanation of any answers and additional evidence: There were records for both the main site and the branch which demonstrated that gas safety and electrical wiring were checked appropriately.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: April 2019 planned for repeat October 2019	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: The practice had a new infection control policy in place. The practice had sought support from an external provider to carry out a comprehensive infection prevention and control audit (IPC). The audit had been risk assessed in line with the practice's risk processes and an immediate plan for redecoration and refurbishment had been completed on the main site. The branch refurbishment was planned and a very detailed action plan was in place for all IPC related actions. There were laminated and dedicated room cleaning schedules in place for all rooms on both sites. The IPC lead had a dedicated support nurse and additional support from the nursing team.	

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.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
Explanation of any answers and additional evidence: The practice had reviewed its workforce capacity and capability and had recruited additional medical and patient services staff. The additional GPs and advanced nurse practitioner had enabled the practice to offer additional appointments and support to	

the growing practice population. The extra patient services staff ensured that there were sufficient support staff during all busy periods and that annual leave was covered. All clinicians had an aide memoir for sepsis management in every clinical room.

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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes
Explanation of any answers and additional evidence: The practice actively monitored the summarising of notes and took steps to ensure that staff knew who to contact if workloads increased.	

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) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.81	0.97	0.87	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). (01/07/2018 to 30/06/2019) (NHSBSA)	10.9%	9.1%	8.6%	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 (01/01/2019 to 30/06/2019) (NHSBSA)	5.75	5.73	5.63	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	1.00	1.80	2.08	Variation (positive)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
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.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about	Yes

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
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.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
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.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
Explanation of any answers and additional evidence: There was a system for recording most test results prior to high risk medicines being prescribed. However, there was a dual system for the result for a blood thinning medicine. The practice was missing one emergency medicine although we could see that they had ordered it.	

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
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	57
Number of events that required action:	57
Explanation of any answers and additional evidence: The practice had acted on the best practice recommendation made at our last inspection in October 2018. The practice had improved its investigative process for significant events (SEA) and demonstrated how they identified all possible contributory factors to an event and how they shared this learning widely across the practice. The practice was also able to show how they considered some complaints as SEAs and how these were treated as both complaints and SEAs.	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
A GP was asked to sign a prescription between patients. The GP did so but had not accessed the patients' medical record before doing so. This resulted in a prescribing error begin made. The error was noticed before the prescription was issued to the patient.	The practice reviewed their process for urgent prescription requests and determined that GPs were not interrupted between patients. Any urgent prescription requests are sent to the duty doctor for review and signing.
A change in medicines a patient required had been missed due to a series of bank holidays and a build-up in workflow. The medicine was changed but had taken a couple of weeks not a couple of days.	The practice revised their workflow process and identified an alert mechanism should external events cause a backlog in workflow so that staff could clear the backlog as a priority. In addition, the practice developed an urgent action procedure to ensure that at very busy times urgent changes were made as required.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: The practice had acted on our best practice recommendation identified at our October 2018 inspection. We saw that there was a clear record of all	

alerts and how they were acted on and shared. However, there was not a clear plan in place for when repeat audits or searches were required.

We saw examples of actions taken on recent alerts for example, regarding sodium valproate which included required risk assessments and onward referral to secondary care.

Effective Rating: Good

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment were delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
Explanation of any answers and additional evidence: The practice used both Clinical Commissioning Group (CCG) guidelines and national best practice guidelines for example, National Institute of Clinical Excellence (NICE).	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHSBSA)	0.39	0.53	0.75	Tending towards variation (positive)

Older people — Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions — Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. The practice used nurse led technology to support the diagnosis of atrial fibrillation.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with chronic obstructive pulmonary disease (COPD) were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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) (QOF)	72.6%	78.2%	78.8%	No statistical variation
Exception rate (number of exceptions).	6.2% (92)	11.7%	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) (QOF)	63.7%	74.8%	77.7%	Tending towards variation (negative)
Exception rate (number of exceptions).	3.8% (57)	10.3%	9.8%	N/A

	Practice	CCG average	England average	England comparison
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) (QOF)	65.9%	79.7%	80.1%	Variation (negative)
Exception rate (number of exceptions).	8.0% (119)	13.9%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	73.6%	76.6%	76.0%	No statistical variation
Exception rate (number of exceptions).	2.2% (32)	11.1%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	88.2%	90.5%	89.7%	No statistical variation
Exception rate (number of exceptions).	5.9% (23)	11.8%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	81.7%	81.4%	82.6%	No statistical variation
Exception rate (number of exceptions).	3.3% (132)	4.6%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug	87.9%	88.3%	90.0%	No statistical variation

therapy (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	3.7% (22)	5.3%	6.7%	N/A

Any additional evidence or comments

The Practice was aware of their higher lower than average results for patients with diabetes. They had made patients with diabetes a specific focus for their work this year. From the monitoring the practice carried out during the year they were confident that these figures were improving.

All exception reporting was discussed at the monthly partners meetings.

Families, children and young people Population group rating: Good

Findings

- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	254	268	94.8%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	248	258	96.1%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	247	258	95.7%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	246	258	95.3%	Met 95% WHO based target

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

Any additional evidence or comments
The practice took every opportunity to explain the benefits of childhood immunisations to relevant patient groups and encouraged parents to bring their children to the surgery. The childhood immunisation clinics always had two nurses at the clinics which encouraged parents to attend and ask questions.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- The practice had added an additional dedicated cancellation telephone line to support patients who no longer required a booked appointment. This enabled cancelled appointments to be released quickly.

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)	75.5%	N/A	N/A	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) **(PHE)**	75.0%	71.7%	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)**	63.7%	58.4%	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)**	71.0%	71.5%	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)	42.0%	47.7%	51.9%	No statistical variation

Any additional evidence or comments
The practice was aware of not having achieved their cervical screening target. They encouraged eligible women to attend for cervical smears when they attended for other appointments.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings
• The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, and cancer. • Same day and longer appointments were offered when required. • There was a system for following up patients who failed to attend for administration of long-term medication. • When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. • Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. • All staff had received dementia training in the last 12 months. • Patients with poor mental health, including dementia, were referred to appropriate services.

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) (QOF)	93.0%	90.7%	89.5%	No statistical variation
Exception rate (number of exceptions).	6.1% (12)	17.1%	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) (QOF)	88.7%	91.7%	90.0%	No statistical variation
Exception rate (number of exceptions).	5.6% (11)	14.8%	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) (QOF)	80.6%	81.3%	83.0%	No statistical variation
Exception rate (number of exceptions).	6.3% (15)	5.4%	6.6%	N/A

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	537.6	543.0	537.5
Overall QOF score (as a percentage of maximum)	96.2%	97.1%	96.2%
Overall QOF exception reporting (all domains)	3.6%	5.8%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Yes
Quality improvement activity was targeted at the areas where there were concerns.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

The practice had conducted a range of clinical and non-clinical audits. The practice had carried out an appointment audit and identified they had excess appointments for nurses, however they then had unexpected staffing issues and the identified capacity was required. The practice identified the number of emergency appointments used, home visits and who made the home visits, for example, GPs or clinical pharmacist. The practice used this audit to plan for appointment demand and skill mix required. They had also recruited additional staff to ensure that they had enough capacity to cope with demand peaks and annual leave.

The practice had also conducted a telephone audit to establish the average length of time people were waiting to get through to the practice. Most calls had been connected to a member of staff within ten minutes.

Any additional evidence or comments

Clinical audits covered a wide range of interests and medicines. For example, a hypnotic prescribing audit was due for its second cycle to be run soon. From the first cycle the practice had identified 330 patients who had received this type of medicine within the last six months and of those patients 180 had a current prescription. The practice had drawn up a new protocol for good prescribing practice in relation to this type of medicine.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A
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.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses and pharmacists.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes

Explanation of any answers and additional evidence:

Staff we spoke with told us that the practice supported their learning and development and that they were well supported.

There was a lead GP for the advanced nurse practitioners and a process was in place for formal supervision. However, not all staff we spoke with understood the review process. There was also a process for informal daily supervision.

The appraisal process included the practice's new value system and staff were encouraged to apply the values to their individual roles. All staff had objectives to meet and the practice shared a collective objective for communication during the current year.

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Yes
We saw records that showed that all appropriate staff, including those in different teams	Yes

and organisations, were involved in assessing, planning and delivering care and treatment.	
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
Explanation of any answers and additional evidence: The practice was working towards accreditation for military veterans and was a veteran friendly practice at the time of our inspection. The practice was also part of the city-wide dementia commitment to the dementia friendly city plan. The city-wide plan included all external stakeholders from the local council highways, transport networks as well as health and social care.	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	96.2%	94.9%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.4% (24)	0.9%	0.8%	N/A

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Policies for any online services offered were in line with national guidance.	Yes
Explanation of any answers and additional evidence: The practice had acted on our best practice recommendation following our October 2018 inspection. They had stopped minor surgery for six months whilst they ensured they updated their policy, and all staff were made aware of the revised consent process. The practice had implemented a comprehensive consent policy and consent forms captured all required information. The patient services team were aware of the requirements for Gillick competency and told us about their role in supporting these patients.	

Well-led Rating: Good

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.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: The practice had supported staff with internal development opportunities and all jobs were advertised externally. Staff development and succession planning were part of business as usual and discussed at partner and team meetings.	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: The practice had developed a new communication strategy since our October 2018 inspection. The practice had developed an information newsletter to staff which was shared on a quarterly basis, and it encouraged staff involvement. The new practice vision was “to deliver the very best healthcare to our patients across Lichfield”. Staff we spoke with knew what the vision was. All staff had been part of team building events held by the partners of the practice and told us that they felt part of the “Westgate Family”.	

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: The practice could demonstrate how they supported staff who were underperforming.	

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Staff	Staff we spoke with told us that they could raise anything with leaders and found the new management structure easy to understand.

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.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence: There were designated lead staff for all key roles, for example, safeguarding and infection prevention and control.	

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.	Yes
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: The new management structure ensured that processes were in place to manage performance and discussed this at clinical and partner meetings.	

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.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence: The Care Quality Commission (CQC) had been appropriately notified about the temporary closure of the branch surgery for refurbishment. We saw that a very detailed plan was in place to support patients during this temporary closure of the Shenstone branch.	

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Yes

Patient records were held in line with guidance and requirements.	Yes
Any unusual access was identified and followed up.	Yes

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: The practice had successfully reformed a Patient Participation Group (PPG) in addition to the virtual PPG group they work with, since our inspection in October 2018.	

Feedback from Patient Participation Group.

Feedback
We were able to speak with five members of the PPG who told us of a variety of things the practice had kept them up to date about. The PPG were very positive about the practice and were aware that the practice was trying to find a workable solution to making appointments first thing in the mornings. The PPG told us that the practice told them about audits being carried out at the practice and how complaints were resolved.

Any additional evidence
We also spoke with seven representatives from local nursing and care homes for whom the practice provided a GP service. The representatives were mainly positive about the practice, however, one told us that they had invited the practice to some shared meetings and the practice had not yet been able to attend.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	

The practice head of operations had successfully bid for improvement and development funds year on year. We saw that the practice had used these funds to make improvements for patients.
New initiatives were identified with the practice team and included in-house anticoagulation clinics; cryosurgery; coil/implant fitting; staying well pathway and electronic consultations. The practice was also involved in research and surveillance, specifically the tracking of the effectiveness of the influenza vaccination.

Examples of continuous learning and improvement

The practice was a training practice for GPs and nursing students. They had excellent links with a number of local universities. The practice shared all learning from audits at practice meetings. Serious events were shared with all staff and learning applied across the whole practice. The practice sought to learn and improve from patient comments and complaints and also treated complaints as significant events when required.

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.
- 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.