CQC PMS Inspections
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Your account number: 1-541171258
Our reference: INS1-2262012249

Henry Okoi
Dr H Okoi Practice
The Derry Court Medical Practice
Derry Crt, Derry Avenue
South Ockendon
Essex
RM15 5GN

14 October 2016

Care Quality Commission
Health and Social Care Act 2008
Factual accuracy check

Location name: Dr H Okoi Practice
Location ID: 1-541171258

Dear Dr Okoi

Comments on Draft Inspection Report (Factual Accuracy)

Following our recent inspection of Dr H Okoi Practice we have drafted the inspection report which is enclosed for your information.

If you have any comments about factual inaccuracies or the completeness of the evidence in the report, please send them to us by 2 November 2016. Any factual accuracy comments that are accepted may result in a change to one or more ratings. You should record your comments using the categories set out in the factual accuracy comments form provided. Please do not send in a pdf format.

If you do not have any comments to make and are happy for the report to be published, we would be grateful if you could please advise us of this prior to the deadline for comments. We can then publish the inspection report on our website.

We would prefer you to send this information to us by email, to this address: HSCA_Compliance@cqc.org.uk. If you are unable to do so, please send it by post to the address shown below.

Please include your account number (1-541171258) and our reference number (INS1-2262012249) in your letter or email as it may cause delay if you do not.

We will review your comments and amend the report if we consider it appropriate to do so. If we do not accept your comments we will explain why.

If we do not receive any comments from you by the date shown above, we will finalise the report and publish it on our website.

Ratings used in the Draft Inspection Report

Your draft inspection report has been produced using our new approach to regulating and inspecting. For NHS GP practices, part of the new approach will be the publication of ratings for each location, at both key question and population group level. Ratings are awarded on a four-point scale; 'Outstanding', 'Good'; 'Requires Improvement', or 'Inadequate'.

We will explain how and when you can request a review of your ratings in the letter we send with the final report. You can only request a review of your ratings if you think we have not followed our published process for awarding ratings.

The table below shows the ratings this location has been awarded:

	Safe	Effective	Caring	Responsive	Well-led	Overall population group
Older people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
People with long term conditions	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Families, children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Working age people and the recently retired	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
People in vulnerable circumstances	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
People experiencing poor mental health	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Overall Key Question	Requires improvement	Good	Good	Good	Requires improvement	

Overall location	Requires improvement

If you have any questions about this letter, you can contact our National Customer Service Centre using the details below:

Telephone: 03000 616161

Email: HSCA_Compliance@cqc.org.uk

Write to: CQC PMS Inspections
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Yours sincerely,

Alexandra Gallagher
CQC Inspector

Enclosed:
- Draft report
- Factual accuracy comment form

Factual Accuracy Comments Form

You are invited to provide comments on the accuracy of this report and the completeness of the evidence on which the ratings are based.

We will be able to respond to your comments more effectively if they are received on this form.

Please note this is your last opportunity to provide evidence that you consider should be taken into account in the report, or comment on the interpretation of evidence or the impact of evidence on the judgement. (This must be limited to evidence that was available at the time of inspection).

Challenging the evidence and ratings

Factual accuracy process (before report publication)

> Ratings can be changed if the evidence on which they are based is wrong or incomplete. Most concerns about ratings errors should be dealt with through this factual accuracy process.

Rating review process (after report publication)

> A rating review involves checking whether or not CQC followed its published methodology (the guidance in the provider handbook and appendices) in making judgements and awarding the rating(s). We will explain how and when you can request a review of your ratings in the letter we send with the final report. A rating review does not involve a reconsideration of the evidence and ratings awarded, unless we find the process has not been followed.

Complaints

Complaints about the conduct of the inspection should be directed to Complaints@cqc.org.uk. They will not be considered as part of the factual accuracy process or a rating review.

Warning Notices/Enforcement Action

Representations should be directed to HSCA_Representations@cqc.org.uk using the appropriate forms. They will not be considered as part of the factual accuracy process or a rating review.

Factual accuracy comments form

Please complete this form and return:
By email to: HSCA_Compliance@cqc.org.uk or
By post to: CQC PMS Inspections, Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA

What does your challenge relate to?	Go direct to:
Typographical/numerical errors	Section A
Accuracy of the evidence in the report	Section B
Completeness of the evidence	Section C
Conduct of the inspection	Complaints via email to Complaints@cqc.org.uk
Representations against a Warning Notice	Representations via email to HSCA_Representations@cqc.org.uk

Account Number:	1-541171258
Our reference:	INS1-2262012249
Location name:	Dr H Okoi Practice
Location address:	The Derry Court Medical Practice, Derry Crt, Derry Avenue, South Ockendon, Essex, RM15 5GN

Completed by (name(s))	Dr Henry Thomas Okoi
Position(s)	Senior Partner
Date	29/10/2016

Section A: Typographical / numerical errors in the draft report

Page No	**Key Question** *e.g. Safe*	**Please set out any typographical or numerical errors** *e.g. Operations Director not Operations Manager* *If the same error occurs more than once, it is sufficient to identify the first occasion, adding "(throughout the report)".*	**CQC decision** ✓or X	**CQC response**

Section B: Other challenges to the accuracy of the evidence in the draft report

Page No	**Key Question** *e.g. Safe*	**Please set out any other challenges to the accuracy of the evidence in the draft report (providing evidence demonstrating the inaccuracy) and describe any impact on the rating(s).** *Challenges to the interpretation of evidence/importance attributed to the evidence should be included here. Any evidence provided must relate to the position on the day of inspection.*	**CQC decision** ✓or X	**CQC response** *If you agree to make amendments you must confirm any impact on breaches or the rating.* *If you choose not to make any amendments you must provide a rationale.*
4	Are services safe?	*The systems for ensuring that some patients prescribed high risk medicines were being monitored appropriately needed strengthening* Your determination that we do not adequately monitor "some high risk medications" is not specific, inaccurate and unsafe. It is not specific because it does not list the medications inspected, and thus creates the impression that you identified a systemic lack of adequate monitoring of medications. However, during the inspection, you asked		

		about and looked at our monitoring of warfarin, Lithium and Methotrexate. You accepted our arrangements for the monitoring of Warfarin. You raised some concerns about the monitoring of Lithium carbonate and Methotrexate even though we disagreed. The determination is not accurate because we do not believe the facts you saw should lead to such a conclusion: 1. Lithium carbonate: you looked at only 1 case involving a patient who has been on Lithium therapy for over 10 years and is very stable on it. This individual last had a blood test to monitor Lithium on 28/1/16. Your inspection date was on 26/7/16. Your inspector stated that we were supposed to test for lithium every 3 months. However we disagree with the inspector because NICE guidelines specifically states that after the first year lithium monitoring should be carried out every 6 months unless the patient was in a high risk group. This patient was not in the high risk group. It follows therefore that your inspector was wrong to require 3 monthly blood tests. In the 12 months prior to your inspection, this individual had 4 blood tests with lithium levels tested 3 times in that same period. The last test was done on 2/8/2016 in keeping with guidelines. In any case, using only 1 case to characterise a service as unsafe is worrying but in this case we have followed NICE guidelines: https://pathways.nice.org.uk/pathways/bipolar-disorder#path=view%3A/pathways/bipolar-disorder/using-pharmacological-treatments-for-bipolar-disorder.xml&content=view-		

		node%3Anodes-monitoring-lithium-treatment 2. Methotrexate: from what we are aware of, this is a national problem that the CQC has come across over and over again. Your inspector did mention that you see this problem very frequently on the day. There are specific problems with the way this medication is managed in the NHS nationally and it seems unfair to blame an individual GP surgery for this national problem. Methotrexate in the NHS is initiated by Consultants usually in secondary care. The cases looked at by the CQC inspector involved only patients taking Methotrexate for Rheumatoid Arthritis. The majority of our patients taking Methotrexate for Rheumatoid Arthritis are under the care of the Rheumatology Department at Basildon and Thurrock Hospital (BTUH). The Consultants from BTUH do not discharge the patients when they initiate Methotrexate but manage them in a shared care arrangement. Under this shared-care arrangement, the patients remain under the Consultants. Each of these patients has letters from the Consultant specifically stating that the Consultant would be carrying out the blood testing for these patients. They are seen every 6 months but the Consultants arrange for the 3 monthly blood tests and update primary care regularly. It would not be right therefore for primary care to stop or alter the medication without the Consultant's agreement. During the CQC inspection on 26/7/2016, your inspector looked at 3 patients on Methotrexate from BTUH. All of them had an up to date letter from the Rheumatology Department stating that the patients had had their regular test and so the medication should continue. The CQC inspector asked if we had seen		

		the results of the blood tests and judged for ourselves that it was appropriate to continue the prescription of Methotrexate. When our senior Partner explained that with the letter from the Consultants we felt satisfied to continue the prescriptions your inspector said we should not trust anyone, and that he advises children not to trust anyone but themselves. He therefore said he would determine that the correspondence from the Rheumatology department asking us to continue prescribing Methotrexate was ambiguous. This was correspondence from the Department who initiated the Methotrexate and review the patients every 6 months. They write to us that they have asked the patients to do tests every 3 months. Yet your inspector said we should not trust them but we must see the results of the tests ourselves. The advice of your inspector not to trust our secondary care colleagues runs contrary to the principles of shared-care or coordinated care where professional trust is important. Over the 30 years history of the surgery, there has not been a single case of Methotrexate toxicity involving any of our patients. We feel therefore that the arrangement with the BTUH Rheumatology department on balance is safe. We have a similarly strong arrangement with the second most frequently used hospital by our patients. During the inspection, one patient was identified who was taking Methotrexate for Rheumatoid Arthritis under the care of the Rheumatology Department at a 3rd Hospital. We agreed with the patient to do a blood test in August 2015 but they did not attend for the test. The patient was seen by the Consultant in October 2015. The Consultant in this case wrote to us that the patient had missed several blood tests but had a test done on the day of the clinic		

		appointment. The Consultant asked us to continue the prescription and wait for a further correspondence on the patient. Unfortunately this correspondence did not follow. This was unusual and it created the impression that the patient was collecting Methotrexate without having blood tests. After the CQC inspection we wrote to the Consultant to establish why they failed to honour their part of the agreement and not write to us as promised. He wrote to us and sent the results of the blood test done during the clinic visit in October 2015. She again had a blood test done on 13 July 2016 for the Consultant but the Consultant did not forward a copy of the report to us, and did not write to inform us. The patient collected Methotrexate till April 2016. This at worst is 6 months from the last blood test and not the 18 months indicated in your report. The patient's blood test done on 13/7/2016 was normal as well. Since the inspection we have written to the Consultant to confirm in a signed agreement their responsibility before we would undertake to prescribe Methotrexate for his patient in order for us to meet CQC regulations. This was the only patient from our surgery under that particular Hospital on Methotrexate treatment. This was a failure of communication from a single Consultant who promised to write to us but did not. However the patient was monitored in secondary care. The patient had tests on 27/4/2015, 27/10/2015 and also on 13 July 2016. The CQC inspector's view on this would have been for us to stop the prescriptions but the Consultant requested us to continue to prescribe. Unfortunately in such cases if we take a zero tolerance approach in primary care, we fear the potential consequences for our patients, but we accept this would make us vulnerable to CQC requirements. We believe that without checking from the Consultant in		

		secondary care that a patient has had their test, it is not safe for the CQC to conclude that a patient has not had the appropriate monitoring. It is a shared-care treatment where the Consultants have specifically stated that they would do the blood testing. However, the CQC seem to look at only one end of the loop and are making a determination without following the patient's journey in its entirety. This makes such a determination unsafe. In the case described above, the CQC inspector stated that the patient did not have a blood test for 18 months while collecting Methotrexate. However, the results from the Consultant show a different picture, even in this less than satisfactory situation we found ourselves. As you stated in your report, the day following the inspection we updated our website to inform patients that we would be carrying out blood tests for medications like Methotrexate. It was not an admission of inappropriate or inadequate care but an act of capitulation, to comply with CQC demand even if we thought it was not going to be popular with our patients. We did receive several protests and complaints because the patients felt it was duplication, in that they were doing regular tests for the hospital. Apart from the cost of such tests, the impact on their lives of having to take time off work in some cases to do the second tests for us is something we find difficult to justify but we have to insist because CQC demand it. We have found no evidence that any of our patients was taking Methotrexate without regular blood test monitoring prior to your inspection, apart from the one individual mentioned above. We have merely duplicated the tests done in the hospitals and a typical patient on methotrexate would be having about 8 blood tests annually. We have patients		

		who are monitored by Rheumatologists from hospitals who do not send blood test results to us and so the only way to meet CQC demand is to test all patients again, but we have not identify any clinical need for this. Hence we believe this determination by CQC is not safe. It may be quality treatment but there is no care in it and patients would needlessly worry that we do not do what we are supposed to do for them. As stated above, the issue with Methotrexate is a national problem. The Hospitals do not routinely forward blood tests to GPs in most cases even when they have carried out the blood test and have written to us stating they have done the tests. *The issue of prescription stationery was not being tracked through the practice* Neither inspector asked about our policy on prescription stationary or how it is tracked through the practice. The GP inspector spent over 5 hours in total speaking directly to our 2 GPs during the inspection. He asked one GP what he does with the prescription paper when he is going home at the end of the day. Our GP explained what he does and the inspector remarked that ideally we should have lockable printers. That was all the discussion you had with us on prescription paper. You did not ask us to show you the request form we used to request our prescription or how we checked it when it arrived. We would have shown you how we allocate prescriptions to prescribers and keep record of the serial numbers. However, you did not request any information on our protocol on tracking prescription paper. To therefore		

		conclude that we do not have ways of tracking prescription paper through the surgery is a surprise to us and very unfair. The CQC inspects different things at different practices and from what we know from other colleagues, you were much more thorough at our surgery that many others visited recently in our area. Whether you forgot to ask for our protocol on prescription paper or otherwise, you cannot conclude that we do not have a process to ensure the security of prescriptions. We would not supply the protocol we have for this because you did not request it on the day of the inspection but we strongly believe you do not have reason to come to the conclusion that our processes are inadequate. The building is locked when the surgery is closed, and the building is not used for any other purpose. There is no public access to the prescription stationary. The surgery has been running for about 30 years and there has not been a single case of misuse or theft of prescription stationary. Hence to conclude that our process of storage is unsafe is not accurate. During the CQC inspection the inspector said ideally we should have lockable printers. We would like to point out that the printers are supplied by NHS England and CCG. We have requested lockable printers. *The business continuity plan did not contact relevant contact details for staff to use in the event of an emergency where services may be disrupted* We absolutely disagree with this determination. On the day of the visit, we gave a large folder with several documents including the business continuity plan. This has all the telephone numbers we feel are relevant. You have		

		stated we did not have telephone numbers in the plan. This is not accurate. You did not tell us on the day of the visit that you had any concerns about our business continuity plan. We have this plan which we sent to the CCG in 2014 when we applied to provide some additional services. We do have all relevant telephone numbers in it. The surgery appointed to use in case of emergency is within 200metres or so from our surgery. We have very close relationship with their staff and GPs and some of us have personal mobile numbers of each other. That said, the business continuity plan does have their contact details. In addition we have the contact numbers for Telecommunications, electricity supplier; IT, water supplier, plumbers, and how to redirect mail, as well as the senior partners bypass number, surgery telephone numbers. We are worried that once again you did not ask for a document but have concluded that we do not have it. This is unfair. We have chosen not to send this business continuity plan as we feel you have already pre-judged us before the inspection. However, if you remove this conclusion and request for the business continuity plan we would provide it. We submitted this to the CCG in 2014 as mentioned above so it is available to them as well. Also we showed you this document on the day of the inspection but you did not raise any concerns about it when you were here. *A risk assessment was not in place to assess the need for emergency medicines.* We did not have some emergency medicines for historical reasons. However we have since changed our decision		

		and bought these medicines to meet CQC requirements, except opiates which we concluded are not needed because of the way we work. We did not put any patient at risk at any time. Your inspector admitted that these days only dispensing surgeries and those in very remote areas keep injectable morphine.		
6	Are services well-led?	*The governance systems in place required strengthening. Some risks to patients had not been identified and mitigated. These included monitoring patients on high risk medicines, managing and acting on medicines alerts, assessing the risk associated with emergency medicines available in the event of a medical emergency and monitoring the use of prescription stationery* We have detailed our response to the issue of monitoring high risk medicines and prescription stationary above. On the day of the inspection, the CQC inspector asked the senior partner who was responsible for acting on medical alerts. Then the inspector asked what would happen if he was on holiday. The GP explained that almost all of the alerts we receive now are via email and he checks his emails on holidays so he would forward this to the other GP as usual. The CQC inspector did not provide any evidence that we have failed to act on any medical alert. You identified that alerts received by the practice are recorded and passed on to the GPs. Most such alerts do not concern primary care and so would not require us to do anything. However we would accept the recommendation by the		

		CQC to record action taken following medical alerts. We would like to mention that the lack of recording of such action does not in any case mean we do not act on medical alerts. We have since the inspection updated our emergency medications. We now have all the recommended medications except Opiates which we have determined we do not need to keep at the surgery. *The practice did not have an effective system in place for monitoring and assessing the quality of services provided through quality improvement* We would like to state that the documents we sent to the CQC before the inspection had at least 5 audits in them excluding the 2 audits mentioned in your report which were looked at on the day of the visit. Hence had you looked at the documents we sent before the inspection, you should have concluded that we showed 7 audits. If that was still not enough and you wanted more, we could have provided. We do not know if the CQC has a minimum number of audits which we would like to know. As you stated in your report the practice scored "comparable or higher than the CCG and national averages" in the Quality and Outcomes Framework (QOF). We scored maximum points in the 2015/2016 QOF. The QOF indicates how we monitor various chronic diseases and carry out screening activities over the whole year. This is not a one off activity. It shows systematic practice. Also evidenced by the latest CQC intelligent report available, the emergency admission rate of the practice is		

		lower than the national average. A recent Public Health England report also showed that our rate of cancer diagnosis through the emergency referral rate is higher than average, placing us among the top 3 or so in the CCG. It is impossible to achieve such outcomes without constantly reviewing the quality of services being provided. We provided a number of quality review reports to the CQC before the inspection. For example 1 year after we changed our appointment system, we carried out a review of appointments covering a 3 month period to assess the effectiveness of this change. We reviewed the impact of this change on staff, and also carried out a patient survey to determine satisfaction rate of the new appointment system. This document has 3 surveys in it. We also included a number of other audits. On the day of the inspection the CQC GP looked at only 2 audits but that does not mean we only had the 2. The 2 were in addition to the ones already sent to the CQC before the inspection. Statements from page 15 of the CQC report suggest we only provided 2 audits but this is not accurate. As mentioned above, the documents we provided to the CQC before the inspection had a number of audits. The 2 were the inspector looked at on the day were additional. We are not sure if the CQC did not look at the documents we sent before the inspection. If so, why are you talking about only 2 audits when as stated above, 1 document alone had 3 audits. We also have other audits and reviews but after the inspector looked at 2 audits he moved on to other things. During the inspection we were asked about our high rate of antibiotic prescribing and also higher than average		

		Ciprofloxacin prescribing. This was explained to the inspector and the actions we took following the report. We also showed the GP inspector recent data that showed our Ciprofloxacin was among the lowest in our CCG as a result of the actions we took following the previous report and our general antibiotic prescribing rate was now lower than the CCG average. These 2 items are quality improvement activities but they were not mentioned in your report. We believe it should have been mentioned that we had become a Training Practice since February 2016. The surgery was visited by the local Deanery and our surgery was approved. This also was not mentioned in your report. Your conclusion therefore about us providing only 2 audits is not accurate. Please look at the pre-inspection documents we sent and you will see at least 5 more Quality improvement activities. You also stated that the medicines management team benchmarks our prescribing. We have various targets they set us. We do not know if the CQC requires a minimum number of audits to prove that we review our service. Hence we only provided a limited number. If we are given a minimum number of quality improvement activities the CQC requires, we would be able to provide them. We hold at least 1 meeting a year with the medicines management team to agree actions that need to be taken and we always follow through what is agreed. We receive reports on our prescribing performance monthly. Each time we receive this report we discuss it at the clinical meeting to identify areas for improvement. We discuss our antibiotic and other medicines prescribing. We also carry		

		out regular review and audits of various medicines for the Medicines management team. However we did not include these in our documents to the CQC because we do not have a minimum number of audits the CQC wants. We regularly hold MDT meetings and meetings with the Palliative teams to discuss various patients and how to best serve them. We have reports of these meetings but we did not consider it necessary to send to the CQC. These reports are reviewed already the CCG. Unless the CQC has a minimum number of audits you want practices to provide, it sounds arbitrary to say we did not provide enough.		
7	Summary of findings	We believe the rating of our services to the six population groups does not reflect your own evidence in the report and certainly differs from the reality of the services we provide. You have not provided any evidence to back your decision that we do not provide at least a good service. You state that we are caring, effective and responsive to people's needs yet you have rated us as not good. You have automatically applied the fact that you have concerns about monitoring "some high risk medications" and so concluded that we require improvement in our services to the six population groups, even though you have listed only positive evidence. We consider this unfair. We have also explained the flaws in the conclusion that we do not monitor medicines adequately. We believe this decision should therefore be reversed.		
11	Background	You determined that our appointments start from 11 am. This is false. We have telephone triage appointments from 9am which carries on till all patients on the day have been triaged. We agree to see patients from the telephone triage consultations and the time for this face to face		

		appointment varies.		
16	Supporting patients to live healthier lives	We were horrified to learn that the CQC blame us for the low uptake of bowel cancer screening by our patients. The bowel screening kits are sent to patients directly without GP involvement. We do not receive prior notice that test kits are being sent to anyone. We only receive reports on the test results after the patients have responded or not. We therefore have no influence on that. When we see patients who have not responded to the bowel cancer screening, many times it is too late and they have already thrown the kits away. We do not receive replacement kits that we could give patients in this case. We have already met with a Public health representative and suggested to give us posters and other materials on the bowel cancer screening to leave in the waiting room but we have not received anything after 6 months. If anything at all, the low bowel cancer screening report shows the challenges we face. When all populations are sent the same testing kits, our population response rate is lower than CCG and national average. However when we intervene in other screenings, our intervention brings us at least comparable to CCG and national average. In many cases, our interventions actually lead to higher outcomes than CCG or national rates. This should rather reflect positively on us as it shows how hard we work given our baseline, and we should not be blamed for the response of patients outside our intervention. When we are in charge, we contact patients repeatedly and with determination till they have had their screening. So, for example our childhood Mumps, Measles and Rubella rate for under 2 year olds was 96% compared to CCG average of 92% and national rate of 91%. This is due to our intervention. We do not have any control over the response rate of the bowel		

		cancer screening. It only shows the challenges we face considering some of our population profiles and does not reflect on our work.		
	Patients waiting long for appoint ments	You mentioned that patients reported that when they attend their appointments it takes long for them to be seen. In fact, any GP would say they wished they could finish their surgery in time. There are many factors which influence the duration of appointments. It is widely known that GP appointments are usually for 10 minutes. Usually this is hardly enough for 1 condition. However many patients come with 2, 3 or even 4 conditions. As a GP you can stick to strictly dealing with 1 condition at a time or be more flexible. If you see anything other than 1 condition in the 10 minutes allocated, you are likely to run over. Also it is very common for parents to make an appointment for 1 child but when they come they bring another child and said this one also has just been found to have a fever. What can you do as a GP? When you wait for a very long time to refer a patient to the hospital, or sometimes you get a call from other professionals who want to discuss other patients, these all add to the time. This is a common issue in all healthcare institutions, including primary care, NHS and independent hospitals.		
	Fire safety	You have written in your determination that we do not have signs on the building warning fire service personnel about the presence of oxygen in our building. The CQC inspector specifically stated on the day that he thought it was a requirement to have a sticker on buildings to warn that there is oxygen inside. However he then said he was not sure if it was a requirement but he felt we should have a sign stating we have Oxygen in the surgery. It is		

		therefore surprising that you should include this in your reasons that our service requires improvement. The day following the CQC inspection, we contacted our Oxygen cylinder supplier who expressed their surprise that the CQC would ask such a thing. They are a major supplier of Oxygen to hospitals and GP surgeries but they said they were not aware of any such requirement. We have annual fire risk and safety inspection by approved personnel. They did not mention anything about oxygen sticker on the building. We have contacted the person who carried out our recent fire safety training and they have also informed us that there is no such requirement. If the CQC would provide us evidence that this is required, we would comply		
Over all impression of CQC visit		We would have liked to be treated similarly to other surgeries we have heard about. We believe we were treated differently. The inspector spent over 5 hours grilling our GPs and concluded differently from the evidence we provided. We were asked several things which were not mentioned in the report and there are things in the report we were never asked. For instance the inspector asked the senior partner to explain what Gillick competency is. He also asked when we would give antibiotics to a child with upper respiratory tract infections. When our GP answered, the inspector responded that children with exudate on their tonsils in other surgeries do not drop dead, suggesting we should not give antibiotics with children with exudative tonsillitis. We were also asked if we were aware of NICE guidelines on managing Hypertension among others! We have detailed our response to the Methotrexate and Lithium carbonate monitoring. We have also written about the fact that the CQC did not appear to have looked at the documents we sent before the inspection which would have shown that		

		we have telephone numbers in our business continuity plan, that we sent several Quality improvement activities than the 2 mentioned in your report, and the fact that we were rated as having no protocol to track blank prescription pads when in fact the CQC did not request to see this. We would welcome an objective, fact finding inspection, but this one appeared different with very inaccurate conclusions. We are a clinical organisation and our priorities are thus focused on clinical outcomes. We have very positive clinical outcomes as evidenced by the QOF and other indicators. However, the CQC is rating us on bureaucracy.		

Section C: Additional relevant evidence that should be taken into account ("completeness")

Page No	**Key Question** *e.g. Safe*	**Please describe (and provide copies of) any additional evidence which you consider should be taken into account in the report.** *Evidence must relate to the position on the day of inspection.*	**CQC decision** ✓or X	**CQC response** *If you agree to make amendments you must confirm any impact on breaches or the rating. If you choose not to make any amendments you must provide reasons.*
		NICE guideline on montoring Lithium Carbonate: https://pathways.nice.org.uk/pathways/bipolar-disorder#path=view%3A/pathways/bipolar-disorder/using-pharmacological-treatments-for-bipolar-disorder.xml&content=view-node%3Anodes-monitoring-lithium-treatment We are not able to provide a copy of the letter from the Consultant about the patient on methotrexate. However, if the CQC clears us to send it, we would be happy to oblige.		

	Business continuity plan	We did give you a folder on the day of the inspection with the business continuity plan in it, which had all the relevant telephone numbers.		
	audits	Please look at the documents sent already to the CQC before the inspection		

CQC use only

Responses prepared by (name)	
Role	
Date	
Responses reviewed by (name)	
Role	
Date	