Care Quality Commission

Inspection Evidence Table

Park Lodge Medical Centre (1-5057630909)

Inspection date: 10 April 2018

Date of data download: 09 April 2018

Safe

Safety systems and processes

Source	
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Policies were in place covering adult and child safeguarding. They were updated and reviewed and accessible to all staff.	Yes
Partners and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs)	No
The practice worked in partnership with other agencies to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. Information about patients at risk was shared with other agencies in a timely way.	Yes
Systems were in place to highlight vulnerable patients on record. There was a risk register of specific patients	Yes
Reports and learning from safeguarding incidents were available to staff.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required	Yes
Staff who acted as chaperones were trained for the role and had a DBS check.	Yes

Explanation of any 'No' answers:

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse.
- All but two members of the administrative staff had received up-to-date safeguarding and safety training appropriate to their role, shortly after the inspection we were provided with evidence that these two members of staff had updated their safeguarding training.
- The safeguarding lead for the practice was also the safeguarding lead for the local CCG. Staff at all levels knew how to identify and report safeguarding concerns. Reports and learning from safeguarding incidents were available to staff.

Recruitment Systems	
The registered person provided assurances that safety was promoted in their recruitment practices.	Yes
Recruitment checks were carried out in accordance with regulations (including for agency staff, locums and volunteers).	Yes
Staff vaccination was maintained in line with current PHE guidance and if relevant to role.	Yes
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Staff who require medical indemnity insurance had it in place	Yes
Explanation of any 'No' answers:	

Safety Records	
There was a record of portable appliance testing or visual inspection by a competent person Date of last inspection/Test:	Yes March 2018
There was a record of equipment calibration Date of last calibration:	Yes March 2018
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals	Yes
Fire procedure in place	Yes
Fire extinguisher checks	Yes
Fire drills and logs	Yes
Fire alarm checks	Yes
Fire training for staff	Yes
Fire marshals	Yes
Fire risk assessment Date of completion	Yes 12/06/2017
Actions were identified and completed. • We saw evidence of appropriate risk assessments in place. For example, in March 2018, following a calibration audit, the practice identified 15 pieces of equipment that had failed the calibration test. This was recorded in a spreadsheet and an action plan was drafted, whereby a named individual had to remove the 15 pieces of equipment by the end of the next day.	Yes
Additional observations:	No

Health and safety Premises/security risk assessment? Date of last assessment:	 Yes 2017
Health and safety risk assessment and actions Date of last assessment:	Yes 2017
Additional comments: • The practice carried out regular health and safety audits none of which had identified any risk. • During our visit the inspection team had no health and safety concerns with purpose built practice.	

Infection control	
Risk assessment and policy in place	Yes
Date of last infection control audit:	September 2017
The provider acted on any issues identified:	No issues identified
Detail: • There was an effective system to manage infection prevention and control (IPC). The lead nurse was the IPC lead. She had received appropriate training to enable the role to be carried out effectively. Audits had been undertaken and actions identified as a result had been implemented. On the day of the inspection, we found that one disposable privacy curtain had not been changed for more than six months. However, this was rectified immediately and we saw that a new curtain had been put in place before we left the location.	
The arrangements for managing waste and clinical specimens kept people safe?	Yes
Explanation of any 'No' answers:	

Any additional evidence

Risks to patients

The practice had systems in place to monitor and review staffing levels and skill mix.	Yes
There was an effective approach to managing staff absences and busy periods.	Yes
Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance	Yes
Staff knew how to respond to emergency situations.	Yes
Receptionists were aware of 'red flag' sepsis symptoms that might be reported by patients and how to respond.	Yes
The practice had equipment available to enable assessment of patients with presumed sepsis.	Yes
There were systems in place to enable the assessment of patients with presumed sepsis in line with NICE guidance.	Yes
The impact on safety was assessed and monitored when the practice carried out changes to the service or the staff.	Yes
Explanation of any 'No' answers:	

Information to deliver safe care and treatment

Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation.	Yes
The care records we saw demonstrated that information needed to deliver safe care and treatment was made available to relevant staff in an accessible way.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented.	Yes
The practice had a documented approach to the management of test results and this was managed in a timely manner.	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
• On the day of the inspection there was some concerns regarding non-urgent correspondence as we noted a backlog of approximately 600 items of correspondences awaiting scanning and sending to relevant clinicians. We were informed that this was due to lack of staffing and only recently had the practice reached full occupancy of administrative staff.	

Safe and appropriate use of medicines

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).**(01/07/2016 to 30/06/2017)**	See Comments	-	-	-
Percentage of antibiotic items prescribed that are Co-Amoxiclav, Cephalosporins or Quinolones.**(01/07/2016 to 30/06/2017)**	See Comments	-	-	-

Medicine Management	
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.	Yes
Staff had the appropriate authorisations in place to administer medicines (including PGDS or PSDs).	Yes
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	Yes
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example audits for unusual prescribing, quantities, dose, formulations and strength). There were arrangements for raising concerns around controlled drugs with the NHS England Area Team CD Accountable Officer. If the practice had controlled drugs on the premises there were systems for the safe ordering, checks on receipt, storage, administration, balance checks and disposal of these medicines in line with national guidance.	Yes Yes NA
Up to date local prescribing guidelines were in use. Clinical staff were able to access a local microbiologist for advice.	Yes
For remote or online prescribing there were effective protocols in place for identifying and verifying the patient in line with GMC guidance.	Yes
The practice held appropriate emergency medicines and .risk assessments were in place to determine the range of medicines held.	Yes
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases	Yes
There was medical oxygen on site The practice had a defibrillator Both were checked regularly and this was recorded.	Yes Yes Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	Yes
Explanation of any 'No' answers:	

- ***Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit***
- ***Percentage of antibiotic items prescribed that are Co-Amoxiclav, Cephalosporins or Quinolones.***

- Park Lodge Medical Centre registered in its current location in April 2017. This means that practice performance data for 2016/17 cannot be used as it relates to performance under the previous registration.
- The practice did manage to contact the NHS Business Services Authority and obtain a breakdown of their performance in relation to antibiotics and hypnotics prescribing, but only for the first three quarters for 2017/2018.
- From the results provided it is clear that Park Lodge Medical Centre is at the lower end of prescribing antibiotics in relation to other practices within the CCG.
- The GP Spa on the day had also informed us that the practice's antibiotic prescribing was low and that he had no concerns.

Dispensing practices only	
There was a GP responsible for providing effective leadership for the dispensary?	N/A
Access to the dispensary was restricted to authorised staff only.	N/A
The practice had clear Standard Operating Procedures for their dispensary staff to follow.	N/A
The practice had a clear system of monitoring compliance with Standard Operating Procedures.	N/A
Prescriptions were signed before medicines were dispensed and handed out to patents. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	N/A
If the dispensary provided medicines in weekly or monthly blister packs (Monitored Dosage Systems) there were systems to ensure appropriate and correct information on medicines were supplied with the pack. Staff were aware of medicines that were not suitable for inclusion in such packs and had access to appropriate resources to identify these medicines. Where such medicines had been identified staff provided alternative options that kept patients safe.	N/A
The home delivery service, or remote collection points, had been risk assessed (including for safety, security, confidentiality and traceability).	N/A
Information was provided to patients in accessible formats e.g. large print labels, braille labels, information in variety of languages etc.	N/A
There was the facility for dispensers to speak confidentially to patients and protocols described process for referral to clinicians.	N/A

Explanation of any 'No' answers: This was not a dispensing practice.

Track record on safety and lessons learned and improvements made

Significant events	
There was a system for recording and acting on significant events	Yes
Staff understood how to 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.	17
Number of events that required action	All significant events required action.

Example(s) of significant events recorded and actions by the practice;

Event	Specific action taken
GP had sent blood test results to the incorrect patient.	The patient had raised the matter and an investigation took place. It became apparent that the GP was working on two patient cases at the same time and had clipped the wrong results to the patients letter and sent them out. After the investigation, the correct results were sent out and formal apology was provided to both patients of concern. As a result of this investigation, the management shared the learning and informed all clinicians that they must not work on two open case notes simultaneously and all letters and results should be double checked prior to sending.
Wrong advice provided to patient with recent cardiac stenting.	A patient had cardiac stenting procedure carried out. They came to see a practice GP and informed them that since taking the medication prescribed by hospital the skin on their hands started to peel. The GP advised to stop taking the medication and see if this improves the condition on their hands. After giving this advice, the GP, consulted with the cardiology unit and informed them of his advice to the patient. The cardiology team advised that the medication prescribed should never be stopped even for a few days as it can lead to high risk of stenting block. The patient was recalled immediately and advised to continue medication. Practice discussed matter at clinical meeting and decided that medicine in these circumstances should never be changed or stopped without consulting a cardiology expert first.

Safety Alerts	
There was a system for recording and acting on safety alerts	Yes
Staff understand how to deal with alerts	Yes

- Comments on systems in place: The practice manager had a system in place to review all safety alerts and cascade them to the appropriate members of staff.

Any additional evidence

Effective

N.B QOF data is incomplete please see the comments section below.

Effective needs assessment, care and treatment

Prescribing				
Indicator	**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). **(01/07/2017 to 30/06/2018)** (NHSBSA)	As above we have seen data provided by NHSBA for first three quarters- the prescribing is lower than most practices in the local CCG.	-	-	-

Diabetes Indicators				
Indicator	**Practice performance**	**CCG average**	**England average**	**England comparison**
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64	59%	-	-	-

mmol/mol or less in the preceding 12 months **(01/04/2017 to 31/03/2018)** (Unverified QOF)				
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	0			
Indicator	**Practice performance**	**CCG average**	**England average**	**England comparison**
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)** (Unverified QOF)	47%	-	-	-
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	0			
Indicator	**Practice performance**	**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)** (Unverified QOF)	56%	-	-	-
QOF Exceptions				
	0			

Other long term conditions				
Indicator	**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. **(01/04/2017 to 31/03/2018)** (Unverified QOF)	63%	-	-	-
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	0			
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months **(01/04/2017 to 31/03/2018)** (Unverified QOF)	86%	-	-	-

QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	0			

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 150/90 mmHg or less **(01/04/2017 to 31/03/2018)** (Unverified QOF)	63%	-	-	-

QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	0			

Indicator	Practice	CCG average	England average	England comparison
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 therapy. **(01/04/2017 to 31/03/2018)** (Unverified QOF)	86%	-	-	-

QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	0			

Childhood Immunisations				
Indicator	**Numerator**	**Denominator**	**Practice %**	**Comparison to WHO target**
Percentage of children aged 1 with completed primary course of 5:1 vaccine. **(01/04/2017 to 31/03/2017)** (NHS England Unverified)	88	98	90%	
The percentage children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) **(01/04/2016 to 31/03/2017) (01/04/2017 to 31/03/2017)** (NHS England Unverified)	55	64	86%	
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) **(01/04/2017 to 31/03/2017)** (NHS England Unverified)	56	64	88%	
The percentage of children aged 2 who have	54	64	84%	

received immunisation for measles, mumps and rubella (first dose of MMR) **(01/04/2017 to 31/03/2017)** (NHS England Unverified)				

Cancer Indicators				
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of women eligible for cervical cancer screening who were screened adequately 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 Unverified)	72%	-	-	-
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE Unverified)	73%	-	-	-
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE Unverified)	58.1%	-	-	-
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. (PHE Unverified)	94%	-	-	-

Mental Health Indicators				
Indicator	**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)** (Unverified QOF)	75%	-	-	-
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
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)** (Unverified QOF)	80%	-	-	-

QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	

Indicator	Practice	CCG average	England average	England comparison
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)** (Unverified QOF)	83%	-	-	-

QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	

Monitoring care and treatment

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	461.66	-	-
Overall QOF exception reporting	0%	-	-

Effective staffing

Question	Y/N
The registered person provided assurances that 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 provider had a programme of learning and development.	Yes
There was an induction programme for new staff. This included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Yes
Staff had access to appraisals, one to one, 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, paramedics, pharmacists and physician associates.	Yes

If no please explain below:

Any further comments or notable training.

- The practice nurse had completed Mental Capacity Act training.
- The practice nurse and doctor confirmed they attend area training events.

- Up to date records of skills, qualifications and mandatory training were maintained in a training overview that enable the practice manager to be confident staff were appropriately training. However, the overview did not include administrative staff, which led to two members of staff not being up to date with their training. Evidence after the inspection was provided to demonstrate that they had now completed their training.

Coordinating care and treatment

Indicator	Y/N
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)** (Unverified QOF)	Y

Helping patients to live healthier lives

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with physical and/or mental health conditions whose notes record smoking status in the preceding 12 months **(01/04/2017 to 31/03/2018)** (Unverified QOF)	92%	-	-	-
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
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)** (Unverified (PHE)	85%	-	-	-

Any additional evidence

QOF and practice performance figures:

- Park Lodge Medical Centre registered in its current location in April 2017. This means that Quality Outcomes (QOF) data for 2016/17 relates to performance under the previous registration. On the day of the inspection, we reviewed unvalidated QOF data for the period between 01/04/2017 to 31/03/2018, and those are the figures inserted in the above tables.

- Unvalidated data for 2017/2018 indicated that the practice had achieved 83% of the total number of points available. Comparisons with local and national averages were not available at the time of the inspection. The practice told us that delays deducting patients who had recently registered with alternative providers from the patient list meant that QOF data for 2017/2018 was unreliable as calculations were made against a larger number of patients than were actually provided with

care by the practice. We were told that the practice was continuing to work with NHSE to resolve this anomaly.

- A CQC GP adviser reviewed the unvalidated data and noted that a significant number of patients could have been excepted from QOF performance and this would have been likely to have had a positive impact on performance.

Evidence of audits:

- The practice had carried out a number of audits in the last year to improve the quality of care. The audits and there results are in the below attachments.
- Two of the audits had two full cycles, these were for Amiodarone prescribing and Gestational Diabetes.
- The results of the Amiodarone audit did not show an increase in performance, whereas the Gestational Diabetes Audit showed a significant improvement.

Caring

Kindness, respect and compassion

CQC comments cards	
Total comments cards received	17
Number of CQC comments received which were positive about the service	8
Number of comments cards received which were mixed about the service	6
Number of CQC comments received which were negative about the service	3

Examples of feedback received:

Source	Feedback
Comments cards & NHS Choices	Comment cards and NHS choices both have very good reviews about the Dr's and the service they provide. All Patients stated that they were always treated with kindness, respect and compassion.

National GP Survey results: The results from the latest annual national GP patient survey could not be used in this inspection, as the period it related to was when the previous provider ran the service.

The practice carries out its own patient survey/patient feedback exercises: No

Date of exercise	Summary of results

Any additional evidence
We interviewed a member of the PPG. They stated on behalf of all members that they were very impressed with the quality of care and the professionalism demonstrated by clinical and admin staff. The surgery telephone line was struggling with managing the two patients lists , and this has been discussed by PPG with management, management in process of reviewing and implementing a more effective telephone system.

Involvement in decisions about care and treatment

Examples of feedback received:

Source	Feedback
Interviews with patients	We interviewed a member of the PPG who confirmed they felt always involved in decisions about care and treatment and that the Dr's make you feel in charge of your own health. She stated that Dr's always try to comply with your personal preferences when it came to advising on relevant treatment and care planning.

Interpretation services were available for patients who did not have English as a first language: Yes

Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations: Yes

Information leaflets were available in easy read format: Yes

Information about support groups was available on the practice website: Yes

Carers	Narrative
Percentage and number of carers identified	• 1% of the patient lists are carers.
How the practice supports carers	• The GP confirmed they have a record template to complete if the patient was identified as a carer. • The practice had provided patients with a named member of staff as the champion for carers; this was advertised in the reception. • Carers table with information about carers association • Twice a year local carers clinic was provided by the practice, where carers had the opportunity to get Flu Jabs and health checks.

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How the practice supports recently bereaved patients	• Practice maintained a death register. • Practice recognised that emotional support was vital during difficult times especially bereavement. • There was a system where all staff was informed of deaths and a policy in place ensuring that the relevant clinicians contact families as early as possible to pay condolences and offer support.

Privacy and dignity

Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments: Yes

	Narrative
Arrangements to ensure confidentiality at the reception desk	Reception area was very open but patients had the option of discussing any confidential matter in a separate room next to the reception.

Consultation and treatment room doors were closed during consultations: Yes

A private room was available if patients were distressed or wanted to discuss sensitive issues: Yes

Examples of specific feedback received:

Source	Feedback
CQC cards	General feedback was that the staff is excellent, they always maintain patient privacy and dignity. The Doctors were noted to be very caring, helpful and pleasant.
PPG Lead	General patient consensus is that privacy and dignity was always maintained to the highest standard.

Responsive

Responding to and meeting people's needs

Practice Opening Times	
Day	**Time**
Monday	**08:00-20:00**
Tuesday	**08:00-18:30**
Wednesday	**08:00-20:00**
Thursday	**08:00-18:30**
Friday	**08:00-18:30**

Appointments available	
	There was both 10 minute and 15 minute appointments available throughout the whole working day, except for the lunch hour. During the inspection – we checked whether there were appointment slots available on the day and in the near future. We saw that appointments were available on the day, 2 days after, within a week and within 2 weeks of the date of inspection.
Extended hours opening	
	Monday and Wednesday open until 8pm.

Home visits	
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention	Yes

If yes, describe how this was done

- The practice had a list of patients who were home bound and unable to access service in person. There was a dedicated Dr who would carry out home visits for these patients.
- If a patient called on the day and requested a home visit, the duty doctor would review their case and triage it accordingly, the patient would be visited on the same day.

Timely access to the service

Examples of feedback received from patients:

Source	Feedback
NHS Choices	• 2 recent comments left on website regarding long queues within surgery and taking up to 30 minutes to get through to surgery on telephone.
CQC Comment cards	• 7/16 comments cards complained about long queues within surgery and taking up to 30 minutes to get through to surgery on telephone.
GP Interview	• A GP we interviewed also raised concerns about the long queues in reception and the time it takes to get through on the phone.

Listening and learning from complaints received

The complaints policy and procedures were in line with recognised guidance and contractual obligations. Yes (See *My expectations for raising concerns and complaints* and *NHS England Complaints policy*)

Information was available to help patients understand the complaints system. Yes

Complaints	
Number of complaints received in the last year.	22
Number of complaints we examined	6
Number of complaints we examined that were satisfactorily handled in a timely way	6
Number of complaints referred to the Parliamentary and Health Service Ombudsman	0

Additional comments:

- Complaints handled in timely manner, investigated by Partners if related to clinical matters, otherwise practice manager. Duty of candour demonstrated in complaints we reviewed. Learning is shared amongst all staff (minutes of meetings seen).

- The practice's management was aware of the complaints regarding long waiting times on the phone and long queues in reception. Staff we spoke with explained that the delays in reception had begun when Park Lodge Medical Centre had had to relocate at short notice which meant there had been a significant increase in activity whilst the number of staff available had not increased. The practice told us the reception team had only recently reached full capacity. Practice management also told us that it was actively reviewing its telephone facility to introduce additional features which would reduce call waiting times.

Well-led

Leadership capacity and capability

Vision and strategy

Practice Vision and values
The practice informed us that their vision and values were as follows: "We are committed to provide the services which will improve the health and well-being of our patients working in partnership with our patients, their families and carers, our practice staff, community health service providers, acute hospitals and the CCG, working within local and national governance, guidelines and regulations." "We are committed to provide the services which will improve the health and well-being of our patients working in partnership with our patients, their families and carers, our practice staff, community health service providers, acute hospitals and the CCG, working within local and national governance, guidelines and regulations."

Culture

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

Source	Feedback
Staff	We were informed that the practice promoted a learning orientated and supportive culture, and the management was always looking to help staff develop and move up in their careers. We noted that two of the partners were previously salaried doctors, and two of the salaried doctors were previously trainees at the surgery. We were informed that the practice promotes continuous learning and encourages staff to take on different roles and become leads for different areas to help develop their careers. We were informed that the staff felt well supported to and listened to by management, if there were any concerns staff would be comfortable in raising them during meetings.

Examples of changes made by the practice as a result of feedback from staff

Source	Example
No evidence	

Examples of the practice responding to incidents and concerns and how they communicate with patients and those involved (consider duty of candour)

Source	Example
Reviewed 6 complaints during the inspection.	• We reviewed six complaints and noted that they were acknowledged, investigated and responded to in a timely manner. • All clinical complaints were investigated by GP partners. • All non-clinical matter would be investigated by the practice manager. • Duty of candour demonstrated in all complaints we reviewed. • Learning was shared amongst all staff members (minutes of meetings seen).

Examples of concerns raised by staff and addressed by the practice

Source	Example
Practice Manager	• The staff raised with management that patients were complaining about long waiting times on the telephone and at reception. • The staff felt under pressure and advised that they needed additional receptionists to deal with patient demand. • As a result there was a strong recruitment drive. • The reception staff had recently reached full capacity, which had eased the pressure on the existing staff.
The practice's speaking up policies are in line with the NHSI National Raising Issues Policy.	Yes

Examples of action taken by the practice to promote the safety and wellbeing of staff

Source	Example
Practice Manager and Lead Clinician	• All staff required to carry out training health and safety training. • Open door policy to provide support to all staff. • Regular staff meetings where concerns can be raised. • Yearly appraisals • All staff offered protected time to develop their knowledge and skills.

Examples of action taken by the practice to promote equality and diversity for staff

Source	Example
Practice Manager and staff files	Equality and diversity training provided to all staff.
Recruitment policy	We saw evidence that Equality and Diversity and Equal Opportunity was promoted

	and considered when the practice recruited for new members of staff.

Examples of actions to improve quality in past 2 years

Area	Impact
A & E attendance and Emergency Admissions	• The practice told us that when they took over the practice, they noted that there was a high rate of unplanned hospital admissions and Accident and Emergency (A&E) attendance. The practice told us they had responded to this by increasing the number of same day appointments, telephone appointments and had put a duty doctor system in place. We were told that his had reduced the rate of unplanned hospital admissions and that A&E attendances had also decreased, although we were unable to see validated data which demonstrated the scale of the improvements..

Examples of service developments implemented in past 2 years

Development area	Impact
Challenges recognised by the practice due to two patients lists being covered by one surgery.	The surgery was now looking after two patient lists which amounted to over 20,000 patients.
Improvements	Large backlog of non-urgent correspondence and to tackle this practice increased scanning hours for the admin staff to reduce the backlog.

Appropriate and accurate information

Staff whose responsibilities include making statutory notifications understand what this entails	Yes

Engagement with patients, the public, staff and external partners

Examples of methods of engagement

	Method	Impact
Patients & Public	PPG	PPG meetings are held regularly and the views of patients are shared and listened to, concerns are noted and action plans put in place, where appropriate.
Staff	Internal communication and	Weekly administrative meetings took place where all staff was updated on current matters. Staff could

	regular meetings	also raise any concerns that they had.

Feedback from Patient Participation Group;

Feedback
Very positive feedback when speaking with PPG lead. She was very happy with the service provided and said that Dr's were caring, supporting and professional. She stated that the surgery staff was continuously looking at new ways to improve and help their patients.

Examples of specific engagement with patients and patient participation group in developments within the practice;

Examples	Impact
PPG meetings	PPG meetings are held regularly, all patients are welcome to attend and minutes shared on surgery website.

Continuous improvement and innovation

Examples of innovation and improvements	Impact on patients
Complaints/ Serious events	Shared amongst patients if issues affect them.
Evening training courses and seminars	Invite external speakers to discuss and train on relevant and recent matters.

Any additional evidence

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, a statistical tool which shows the deviation from the England average. It gives us a statistical measurement of a practice's performance in relation to the England average, and measures this in standard deviations. We calculate a z-score for each indicator, thereby highlighting the practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are +2 or more or -2 or less are at significant levels, warranting further enquiry.

N.B. Not all indicators are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for banding variation:

Significant variation (positive)

- Variation (positive)
- Comparable to other practices
- Variation (negative)
- Significant variation (negative)

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95%.

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: