

Care Quality Commission

Inspection Evidence Table

Elmdene Surgery (1-540476120)

Inspection date: 12 July 2018

Date of data download: 05 July 2018

Please note: Any Quality Outcomes Framework (QOF) data relates to 2016/17.

Safe

Safety systems and processes

Safeguarding	Y/N
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.	YES
Policies 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)	YES
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	PARTIAL
Disclosure and Barring Service checks were undertaken where required	PARTIAL
Explanation of any 'No' answers: We found that the lead GP partner had experience of reporting safeguarding concerns to the appropriate organisations and had maintained clear records of this. The practice had a system to identify vulnerable patients. They used their Quality Outcome Framework to manage specific vulnerable patients and the IT system had a flag on the computer screen for the information of clinicians. There was a register of patients living with a learning disability and of carers. We found that staff who acted as chaperones were trained for their role but had not all received a DBS check. For example, the practice nurses had received a DBS check, but the administration team, who did act as chaperones, had not.	

Recruitment Systems	Y/N
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	PARTIAL

Staff vaccination was maintained in line with current Public Health England (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 answers: We found that a member of non-clinical staff employed in March 2018 did not have references in their personnel file.	
Safety Records	Y/N
There was a record of portable appliance testing or visual inspection by a competent person Date of last inspection/Test:	YES 25/06/2018
There was a record of equipment calibration Date of last calibration:	YES 25/01/2018
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals	NO
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	NO
Actions were identified and completed.	N/A
Additional observations:	N/A
Health and safety Premises/security risk assessment? Date of last assessment:	NO N/A
Health and safety risk assessment and actions Date of last assessment:	NO N/A
Additional comments: The health and safety policy was generic and had not been tailored to the practice or completed.	

Infection control	Y/N
Risk assessment and policy in place Date of last infection control audit: The practice acted on any issues identified	PARTIAL
The arrangements for managing waste and clinical specimens kept people safe?	YES
Explanation of any answers: The practice did not effectively manage infection control risks. We found there was an infection control policy. However, there was no risk assessment. A basic audit had been carried out, but this did not list actions to be taken or their date of completion. Some infection control risks were noted during the inspection. For example, there was a patch of corrosion on the surface of the nurse work station in one treatment room at Elmdene Surgery; a hole in the wall in the treatment room next to the sink at Elmdene Surgery; the patients' toilet seat was split in half at The Bean Surgery; there were open bins in the treatment room and toilet at Elmdene Surgery.	

Risks to patients

Question	Y/N
There was an effective approach to managing staff absences and busy periods.	NO
Comprehensive risk assessments were carried out for patients.	YES
Risk management plans were developed in line with national guidance.	YES
Staff knew how to respond to emergency situations.	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
In addition, there was a process in the practice for urgent clinician review of such patients.	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 National Institute for Health and Care Excellence (NICE) guidance.	YES
Explanation of any answers: There had been no practice manager in post for two years across the three surgeries. Dr Bora, lead partner GP had been working ten clinical sessions a week across these sites and two others, whilst also acting as manager of the practice. Staff had recently had training in Sepsis, including administrative and reception staff. They had completed basic life support training	

Information to deliver safe care and treatment

Question	Y/N
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Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation.	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
<p>Explanation of any answers:</p> <p>The practice had recorded a significant event regarding a delay in cancer diagnosis in June 2017. This resulted in a discussion between the GPs at the practice and a reminder to use the correct referral template. There were no further events recorded regarding referrals.</p> <p>The practice had recorded and investigated a significant event regarding the practices failure to review a scanned letter with patient information in a timely manner. As a consequence, the practice established a generic inbox for all correspondence to help ensure that all letters and documents were resolved the day they were received.</p> <p>We found the practice managed patient test results in a timely manner. A significant event regarding the scanning of a letter with patient information resulted in a generic inbox being established to help ensure that all letters and documents were resolved the day they were received.</p>	

Appropriate and safe 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)(NHS Business Service Authority - NHSBSA)	1.01	1.06	0.98	Comparable to other practices
Percentage of antibiotic items prescribed that are Co-Amoxiclav, Cephalosporins or Quinolones.(01/07/2016 to 30/06/2017) (NHSBSA)	13.8%	10.3%	8.9%	Comparable to other practices

Medicines Management	Y/N
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 Patient Group Directions or Patient Specific Directions).	YES
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	PARTIAL
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical	NO

review prior to prescribing.	
The practice monitored the prescribing of controlled drugs. (For example audits for unusual prescribing, quantities, dose, formulations and strength).	NO
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	NO
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.	NO
Up to date local prescribing guidelines were in use.	YES
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 General Medical Council guidance.	YES
The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.	NO
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	PARTIAL
There was medical oxygen on site.	PARTIAL
The practice had a defibrillator.	PARTIAL
Both were checked regularly and this was recorded.	NO
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	NO
<p>Explanation of any answers:</p> <p>At The Bean Surgery, the vaccine fridge also stored other medicines, including insulin and this had repeatedly breached the 8C high temperature limit. In June 2018 the maximum temperature had breached 8C on 25 of the 35 times it was recorded from 8.8C to 14C. In July 2018 the maximum temperature had breached 8C on 12 of the 13 times it had been recorded, between 8.8C and 10C. On 20 June 2018 the actual temperature was 11C and on 22 June 2018 the actual temperature was 9C. The breaches of cold chain may affect the integrity of the medicine.</p> <p>At Bennett Way Surgery there was one occasion on 21 June 2018 when the maximum temperature for the dispensary fridge was recorded as '12?', and on 6 July 2018 and 10 July 2018 the maximum temperature read as 10C. The temperature recording form stated, 'Inform Practice Manager if Fridge Temperature falls below 2C or above 8C at any time'. We found the comments boxes just stated 'Reset' and provided no narrative explanation for the fluctuations in temperatures that may have affected the integrity of the medicines.</p> <p>This was discussed with the lead partner GP during feedback and he told us that he was not aware of the breach in maximum temperatures but did inform us that a new fridge had just been purchased at Elmdene Surgery. However, the dates recorded for the new fridge still breached the maximum temperature for the safe refrigerated storage of medicine. The fridge temperatures for 9 July to 12 July 2018 inclusive had all been above the 8C maximum in a 24-hour period.</p>	

We found that there were numerous dates at Elmdene Surgery where the vaccine fridge temperature had not been recorded. - 19 June 2018; 20 June 2018; 21 June 2018; 25 June 2018; 26 June 2018; 3 January 2018; 5 January 2018; 11 January 2018; 18 January 2018; 24 January 2018 and 31 January 2018; 5 March 2018; 6 March 2018; 16 March 2018 and 20 March 2018; 14 February 2018; 18 February 2018 and 21 February 2018 and 11 May 2018.

We found that there was no system for the safe storage of medical gases across all three sites Elmdene Surgery, The Bean Surgery and Bennett Way Surgery. The oxygen stored at Elmdene Surgery was leaning against a wall in one of the consulting rooms. The gauge read as empty. There was no signage on the door to alert people to the oxygen stored and the cannister was not on a trolley, in a bag or chained to restrain it and prevent it falling.

The oxygen at The Bean Surgery was stored unrestrained in a cupboard behind other objects. There was no signage to alert people to its position.

The oxygen at Bennett Way Surgery was stored on its side on a shelf, was not restrained and there was no signage.

There was not a systematic approach to the provision of emergency equipment. There was an automated external defibrillator (AED) at Elmdene Surgery, however, there was not one at either The Bean Surgery or Bennett Way Surgery. (An AED is a portable electronic device that automatically diagnoses life threatening cardiac symptoms and can treat these by using electricity to re-establish an effective heart rhythm). We were told that this was due to their proximity to Darenth Valley Hospital. Both sites were approximately two miles away and between six and eight minutes' drive without traffic from the hospital. This would reduce a patient's potential of receiving timely life critical access to emergency provision. There was no risk assessment regarding this.

There was not a system for the management of emergency medicines. We found that there were a number of emergency medicines not available at Elmdene Surgery. -There was no Chlorphenamine for injection (anaphylaxis or acute angio-oedema); no Dexamethasone 5mg/2.5ml oral solution (Croup – children); no Diclofenac intramuscular injection (Analgesia); no furosemide or bumetanide (left ventricle failure); no Glyceryl trinitrate (GTN) spray or unopened in date GTN sublingual tablets (chest pain of possible cardiac origin); no hydrocortisone for injection or soluble prednisolone (acute severe asthma, severe or recurrent anaphylaxis; no opiates – diamorphine, morphine, pethidine ampules for injection (severe pain including myocardial infarction). The practice had not recorded a risk assessment to evidence why these emergency medicines were not available for emergency use and how they would mitigate the risks to patients.

There was no consistent system employed for monitoring emergency medicines. At Elmdene Surgery and Bennett Way Surgery these were checked monthly for expiry dates and at The Bean Surgery they were checked every two months. The last check at The Bean Surgery was completed in July 2018, however, there was no indication which medicines were short dated. We found Rapilose Gel, (Rapilose Gel is a fast-acting glucose gel that provides rapidly absorbed carbohydrates to increase the body's blood sugar levels quickly) was due to expire August 2018 before the next date check and Adrenaline 1 in 1000 expiring September 2018.

The system to monitor patients' in relation to their use of medicines was not reliable. We found the practice did not have a policy for the management of high risk medicines.

Medicine reviews were not being carried out appropriately. The practice had 26 patients who were prescribed the medicine Methotrexate. We selected ten random patient records to assess the monitoring of the patients in line with national best practice. We found four of the ten patients were late to be reviewed and only one of these had been contacted by the practice. (Patients should have full blood count and renal and liver function tests repeated everyone to two weeks until therapy is stabilised. Thereafter patients should be monitored every two to three months. Failure to have established systems to monitor Methotrexate places them at risk of developing side effects such as bone marrow suppression (including fatalities), liver toxicity, pulmonary toxicity and gastro-intestinal toxicity).

We looked at the management of patients receiving Lithium. The records of four patients who were prescribed Lithium were checked and two of these were late to be reviewed. (Lithium is a medicine used to manage mood disorders such as bi-polar disorder). It is recommended that patients receive three monthly monitoring including having a blood test to check their lithium levels and six-monthly thyroid, cardiac and renal function monitoring. Failure to monitor a patient on Lithium places them at risk of sub-optimal treatment (for example continuing mood changes), or the risk of experiencing side effects (for example gastro-intestinal disturbances, confusion and muscle weakness), if the dose is too high.

The records of ten out of 15 patients prescribed Azathioprine (an immunosuppressive medicine) were looked at and we saw that four of these reviews had not been carried out.

The lead GP partner sent an email responding to concerns raised on 13 July 2018 and the action that would be taken to mitigate these, and the Dartford Gravesham and Swanley Clinical Commissioning Group (CCG) were informed of concerns on 13 July 2018 and established a plan to support the practice.

The CCG medicines management team attended the practice and devised an action plan with the lead GP partner on 18 July 2018.

Dispensing practices only	Y/N
There was a GP responsible for providing leadership for the dispensary.	PARTIAL
Access to the dispensary was restricted to authorised staff only.	YES
The practice had clear Standard Operating Procedures for their dispensary staff to follow.	NO
The practice had a clear system of monitoring compliance with Standard Operating Procedures.	NO
Prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	YES
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.	YES
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	NO

been identified staff provided alternative options that kept patients safe.	
The home delivery service, or remote collection points, had been risk assessed (including for safety, security, confidentiality and traceability).	NO
There was the facility for dispensers to speak confidentially to patients and protocols described process for referral to clinicians.	NO
Explanation of any answers	
<p>Any other comments on dispensary services:</p> <p>There was a named GP to provide leadership for the dispensaries, however, both lacked governance systems and oversight.</p> <p>Bennett Way Surgery and The Bean Surgery both had dispensaries. The arrangements for dispensing medicines did not keep patients safe and there was a lack of governance and oversight. The practice was unable to provide evidence of standard operating procedures (SOP) other than for controlled drugs at The Bean Surgery and the SOP's at Bennett Way had not been signed by staff currently employed.</p> <p>Medicines dispensed at The Bean Surgery were not routinely second checked. A staff rota was requested and staff confirmed that of the five sessions each week that the dispensary was open, one of these the dispenser worked completely alone in the surgery, for four sessions they worked single handed and for one of these there was no GP or nurse in the building. This meant they had no one to check safe issuing of medicines or seek guidance from if concerned.</p> <p>The practice did not have a system to monitor medicines that were not collected by the patient. At The Bean Surgery we found two dispensed medicines waiting to be collected. We found a Pulmicort Turbohaler had been dispensed on the 29 May 2018 and was not signed as checked by dispenser. The medicine had not been collected 44 days later and no enquiries made with the patient. We also found Ibuprofen had been dispensed on the 9 July 2018, it had one signature to show it had been checked, but had not been collected by the patient.</p> <p>The practice did not have a system to monitor prescriptions that had not been collected. At The Bean Surgery we found prescriptions from October 2017 for medicines including, Fluoxetine 3/ October 2017; Mirtazapine 1 November 2017; Indapamide 28 December 2017; Ventolin inhaler/ Symbicort inhaler 9 February 2018.</p> <p>The practice did not have a system to ensure that only suitable medicines were included in dosett boxes. At The Bean Surgery a dosett box was found to include a medicine prescribed for the treatment of generalised, partial or other epilepsy. This medicine was hygroscopic and the manufacturers instruction stated that there were special precautions for its storage, which included not removing the tablets from their foil until immediately before they were taken. This medicine was seen to be included, outside of the foil, in dosett boxes made up for a four-week period. The practice were not able to provide a risk assessment to support why the manufactures instructions had been disregarded.</p> <p>The practice did not have a system for monitoring medicine errors or to carry out audits to improve quality. At The Bean Surgery there was no formal records of medicines incidents or near misses. A member of the dispensary team told us of a recent medicine dispensing error where a patient had been give lansoprazole capsules instead of orthodispersible tablets. There was no record of this at surgery level and it had not been raised as a significant event.</p>	

At Bennett Way Surgery, the staff could evidence that medication errors were reported on significant incident forms. However, there was no recorded outcome of how learning was shared with the practice team and changes embedded. An error in April 2018 was recorded on a significant event form but the dispensers did not know the outcome of this. (The error was suppliers sent wrong strength of Aspirin 300mg instead of 75mg. The dispensers picked this up before it went out to patient). These were not presented as part of the significant events occurring at the practice over the last 12 months.

We found there was no protocol for the practice to deliver medicines to a patient's home.

There was no system to ensure the safe management of prescription paper at either Elmdene Surgery, The Bean Surgery or Bennett Way Surgery, in accordance with national guidance on the security of prescription forms. Although this was stored locked in the dispensaries, the serial numbers of prescriptions were not recorded and therefore the practice could not know if some had been removed or not. Staff acknowledged that this was the case.

The practice did not ensure the safe and secure management of high risk medicines. A schedule 2 controlled drug Methylphenidate (Ritalin) was found on the shelf in the dispensary at Bennett Way Surgery. We informed the dispensary staff who told us that were not aware of this and did not know where it had come from. They responded by locking it into the controlled drug cupboard.

We found the practice had not maintained an accurate record of the destruction of controlled drugs. We found 20 ampules of Morphine Sulphate 10mg. These were recorded in the controlled drug register with 10 being received on 12 December 13 and 10 on 11 September 14. They were noted to be out of date on 3 August 17 and the quantity supplied reduced from 20 to 0. However, this medicine is not recorded in the controlled drugs destruction log as one of the drugs destroyed on the destruction date 08 January 2018.

Track record on safety and lessons learned and improvements made

Significant events	Y/N
There was a system for recording and acting on significant events	NO
Staff understood how to report incidents both internally and externally	NO
There was evidence of learning and dissemination of information	NO
Number of events recorded in last 12 months.	4
Number of events that required action	4+

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

Event	Specific action taken
The practice managed a non-compliant patient.	Referred to Accident and Emergency as presented unwell.
The practice investigated a delay in a patient receiving their cancer diagnosis delay. It was identified that the correct referral template was not used. An urgent letter was sent rather than the two week referral template. It failed to reach the correct clinic and led to a delay which was only discovered when the patient returned to chase the referral.	The practice identified failure by staff to adhere to defined systems and use the right forms when making referrals. They encouraged discussion with colleagues/peers to obtain guidance where the staff member was unsure. Implemented a system to follow up on two week referrals to ensure they were being managed in a timely manner.
The practice investigated a delay in actioning a hospital letter. This was found to be due to GP absence and an absence of system to ensure correspondence was being reviewed and actioned appropriately. For example, a change to a patient's medicine.	The practice established a generic inbox for all correspondence. The appointed duty doctor on the day was assigned to ensure all the correspondence were reviewed and where possible actioned on the day itself.
The practice investigated a missed Hypothyroid diagnosis.	The practice shared their learning and staff were informed to now follow up abnormal results either by phone. A record was being maintained.

Safety Alerts	Y/N
There was a system for recording and acting on safety alerts	PARTIAL
Staff understand how to deal with alerts	PARTIAL
Comments on systems in place: The lead GP partner was the GP lead for safety alerts. We found that appropriate searches had been	

carried out. However, the dispensary team told us they did not receive safety alerts.

Any additional evidence

The practice recorded and investigated four significant events for a 12 month period. It was unclear who they had been discussed with, however, some improvements were made to the practice as a result. Where there had been delay in actioning a hospital letter to change a patient's medication due to a GP being on holiday, a generic inbox was established to help ensure that no other changes were missed. However, there were significant events recorded at Bennett Way Surgery which had not been included in the total events for the year, dispensing errors were not consistently recorded or shared, some staff recorded their own incidents and did not share them, and events that were significant, such as the fridge temperature exceeding the maximum temperature were not recorded as such. The practice were not able to demonstrate how they shared events or learned from them.

Effective

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). (01/07/2016 to 30/06/2017) <small>(NHSBSA)</small>	0.89	1.06	0.90	Comparable to other practices

People with long-term conditions

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 mmol/mol or less in the preceding 12 months (01/04/2016 to 31/03/2017) <small>(QOF)</small>	61.0%	76.4%	79.5%	Variation (negative)
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	4.9% (18)	15.8%	12.4%	
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 (01/04/2016 to 31/03/2017) (QOF)	62.7%	76.0%	78.1%	Variation (negative)
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	5.8% (21)	11.7%	9.3%	
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 (01/04/2016 to 31/03/2017) (QOF)	60.1%	77.7%	80.1%	Significant Variation (negative)
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	7.7% (28)	14.9%	13.3%	

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. (01/04/2016 to 31/03/2017) (QOF)	67.0%	77.2%	76.4%	Comparable to other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	4.5% (17)	10.8%	7.7%	
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 (01/04/2016 to 31/03/2017) (QOF)	81.4%	92.3%	90.4%	Comparable to other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	5.2% (8)	15.1%	11.4%	
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 (01/04/2016 to 31/03/2017) (QOF)	78.3%	82.7%	83.4%	Comparable to other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	6.0% (56)	4.7%	4.0%	
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. (01/04/2016 to 31/03/2017) (QOF)	90.8%	89.9%	88.4%	Comparable to other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	8.4% (7)	6.5%	8.2%	

Any additional evidence or comments

Negative variations and lower than average QOF scores were discussed and staff acknowledged that in relation to diabetes there was a poor recall system, which needed to be improved. Incorrect coding was found in relation to patients with diabetes, for example, a patient who was pre-diabetic had been coded as diabetic. The results also demonstrate lower than average exception reporting.

Incorrect coding had an impact on targets across the practice. For example, in the SIP, there is a low score for patients with depression being reviewed 10 to 56 days after diagnosis 9% compared to 69% as a local average and 65% as a national average. The practice were coding patients with long standing depression as new, when they should have been coded as a follow up. The random four selected to be reviewed were all coding errors. None of the patients were newly diagnosed with depression.

In the SIP there is a low score for patients newly diagnosed with cancer receiving a review within six months. This was 36% compared to 70% as a local average and 71% as a national average. This was identified as a coding issue, for example, a patient with a historic diagnosis of cancer from 2013 had been coded as new with no review; a second newly diagnosed patient had been followed up with a review documented, but this was not Read coded. There was evidence that care was being received by the patients but that this was not being coded correctly. All the four records selected were incorrectly coded.

Families, children and young people

Child Immunisation				
Indicator	Numerator	Denominator	Practice %	Comparison to WHO target

Percentage of children aged 1 with completed primary course of 5:1 vaccine. (01/04/2016 to 31/03/2017) (NHS England)	102	111	91.9%	Met 90% Minimum (no variation)
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) (NHS England)	105	118	89.0%	Below 90% Minimum (variation negative)
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) (01/04/2016 to 31/03/2017) (NHS England)	107	118	90.7%	Met 90% Minimum (no variation)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (first dose of MMR) (01/04/2016 to 31/03/2017) (NHS England)	105	118	89.0%	Below 90% Minimum (variation negative)

Working age people (including those recently retired and students)

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 (01/04/2016 to 31/03/2017) (Public Health England)	74.2%	74.0%	72.1%	Comparable to other practices
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE)	63.1%	71.3%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE)	47.5%	53.3%	54.5%	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. (PHE)	37.5%	69.5%	71.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2016 to 31/03/2017) (PHE)	68.8%	50.7%	51.6%	Comparable to other practices

People experiencing poor mental health (including people with dementia)

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	81.5%	91.1%	90.3%	Comparable to other practices

documented in the record, in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)				
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	1.8% (1)	14.3%	12.5%	
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 (01/04/2016 to 31/03/2017) (QOF)	70.4%	87.9%	90.7%	Variation (negative)
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	1.8% (1)	11.7%	10.3%	
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 (01/04/2016 to 31/03/2017) (QOF)	86.8%	83.7%	83.7%	Comparable to other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	3.6% (2)	6.2%	6.8%	
Any additional evidence or comments				
The exception reporting for the negative variation is significantly lower than the local and national average. 2% compared to 12% and 10% respectively.				

Monitoring care and treatment

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	458	527	539
Overall QOF exception reporting	5.0%	6.5%	5.7%

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 (01/04/2016 to 31/03/2017) (QOF)	NO

Helping patients to live healthier lives

Indicator	Practice	CCG	England	England
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		average	average	comparison
The percentage of patients with physical and/or mental health conditions whose notes record smoking status in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	91.0%	93.8%	95.3%	Comparable to other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	1.0% (15)	0.9%	0.8%	

Consent to care and treatment

Description of how the practice monitors that consent is sought appropriately

There were no surgical procedures provided at the practice. Consent was implied or verbal. Where verbal consent was given, for example in relation to immunisations, this was recorded on the patients care records.

Caring

Kindness, respect and compassion

CQC comments cards

Total comments cards received	7
Number of CQC comments received which were positive about the service	3
Number of comments cards received which were mixed about the service	4
Number of CQC comments received which were negative about the service	0

Examples of feedback received:

Source	Feedback
Comments cards	Feedback received from patients included that the service provided excellent, professional, respectful care in clean surroundings. Reception staff were praised as friendly and helpful and always willing to help. The team were considered caring and kind. Four patients also mentioned that it is sometimes difficult to get an appointment.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
8,860	307	113	36.81%	Surveys returned divided by Practice population) x 100

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (01/01/2017 to 31/03/2017)	84.6%	73.2%	78.9%	Comparable to other practices
The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at listening to them (01/01/2017 to 31/03/2017)	87.4%	86.7%	88.8%	Comparable to other practices
The percentage of respondents to the GP patient survey who answered positively to question 22 "Did you have confidence and trust in the GP you saw or spoke to?" (01/01/2017 to 31/03/2017)	94.5%	94.0%	95.5%	Comparable to other practices
The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern (01/01/2017 to 31/03/2017)	82.5%	82.2%	85.5%	Comparable to other practices
The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at listening to them (01/01/2017 to 31/03/2017)	91.0%	91.9%	91.4%	Comparable to other practices
The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern (01/01/2017 to 31/03/2017)	85.5%	90.9%	90.7%	Comparable to other practices

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	N

Involvement in decisions about care and treatment National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at explaining tests and treatments (01/01/2017 to 31/03/2017)	86.3%	83.4%	86.4%	Comparable to other practices
The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions about their care (01/01/2017 to 31/03/2017)	77.8%	77.7%	82.0%	Comparable to other practices
The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at explaining tests and treatments (01/01/2017 to 31/03/2017)	94.1%	89.1%	89.9%	Comparable to other practices
The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at involving them in decisions about their care (01/01/2017 to 31/03/2017)	86.4%	84.7%	85.4%	Comparable to other practices

Question	Y/N
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 about support groups was available on the practice website.	YES

Carers	Narrative
Percentage and number of carers identified	The practice had identified 44 carers which was just under 0.5% of their patient list.
How the practice supports carers	The practice were not proactive in identifying carers. There was no carers pack, no carers champion and no literature regarding support organisations

	available in the waiting area. Information for carers was available on a practice IT system and could be accessed by clinicians if required.
How the practice supports recently bereaved patients	Staff told us that there was no formal support but that a GP may carry out a visit to the bereaved family.

Privacy and dignity

Question	Y/N
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	YES

Question	Y/N
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

Responsive

Responding to and meeting people's needs

Practice Opening Times Elmdene Surgery	
Day	Time
Monday	7.30am – 6.30pm
Tuesday	7.30am – 8pm
Wednesday	8am – 8pm
Thursday	8am – 1pm
Friday	8am – 6.30pm

Home visits	Y/N
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 GPs triaged the calls for home visits.	

Timely access to the service

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
8,860	307	113	36.81%	Surveys returned divided by Practice population) x 100

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who were 'Very satisfied' or 'Fairly satisfied' with their GP practices opening hours. (01/01/2017 to 31/03/2017)	66.2%	72.0%	80.0%	Comparable to other practices
The percentage of respondents to the GP patient survey who gave a positive answer to "Generally, how easy is it to get through to someone at your GP surgery on the phone?" (01/01/2017 to 31/03/2017)	57.3%	58.7%	70.9%	Comparable to other practices
The percentage of respondents to the GP patient survey who stated that the last time they wanted to see or speak to a GP or nurse from their GP surgery they were able to get an appointment (01/01/2017 to 31/03/2017)	63.6%	68.7%	75.5%	Comparable to other practices
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2017 to 31/03/2017)	66.5%	63.3%	72.7%	Comparable to other practices

Listening and learning from complaints received

Complaints	Y/N
Number of complaints received in the last year.	6
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:	
The practice has a comments facility on their website which is linked to the lead GP partners email address. We found that there were 62 comments recorded on the website equally split between positive and negative and that these could be replied to.	

The practice used a texting service to remind patients of their appointment and to obtain feedback. They used the feedback to make improvements to the service provided. After a meeting on 21 May 2018 to review the feedback, the practice introduced new measure such as extending the pre-bookable appointment system from two weeks to four weeks; putting some emergency appointments at the beginning of each morning surgery so that patients who went to the practice to book their appointment did not need to go home again.

Example of how quality has improved in response to complaints

We found that there had been complaints regarding the approach of some reception staff and that additional training had been provided and a buddy system introduced.

Well-led

Leadership capacity and capability

Examples of how leadership, capacity and capability were demonstrated by the practice

The practice had recently moved from three GP partners to two, which had an impact on capacity. The practice was spread across three sites, all within 10 minutes drive of the main location which was Elmdene Surgery. The patient list had grown rapidly from 6000 patients in 2016 to approximately 9100 patients registered on the day of the inspection. There was a significant amount of new building work taking place around the immediate area of the practice which would enable the practice to provide services to a greater number of patients.

The practice currently had two GP partners, one long term locum and the use of agency locums on a Friday at one of the branch practices. Two salaried female GPs had been recruited to start work on 1st August 2018 across all sites. There were two practice nurses and one of these was a prescribing nurse.

The GP partners had an additional location in another area with approximately 3000 registered patients and one of the partners has a second partnership at a further practice.

There had been no practice manager in post for two years and the lead GP partner had been managing as well as working 10 clinical sessions each week. A sustained and consistent approach to leading the practice was necessary to help ensure that it is able to demonstrate fully its capacity and capability to provide safe care and treatment.

Any additional evidence

The practice had been without a skilled and experienced practice manager for a two year period, and although they had promoted administrative staff to the role of practice supervisors, they had not sufficiently supported this to be a management position.

Vision and strategy

Practice Vision and values

There was a clear vision and the practice had a strategy and supporting business plans to achieve priorities. These were focused on the stabilisation of the clinical work force with the appointment of two

salaried GPs due to start working at the practice on 1 August 2018; the continued improvement of patient access to care and treatment and the development along with the clinical commissioning group and two other practices, of a larger building for Elmdene Surgery.

Culture

Examples that demonstrate that the practice has a culture of high-quality sustainable care

We found that staff did not consistently feel respected, supported and valued. The Dispensary team told us that they did not feel supported by the practice and did not feel that they could question the procedures and processes.

We found that staff were aware of concerns, but did not consistently know how to raise them and in some instances kept their own records. There was not a clear system to raise concerns and staff told us that they did not have confidence that these would be addressed.

Governance arrangements

Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care.

Practice specific policies	The policies were not all practice specific and did not have a date they were established or the name of an accountable person who had completed this task. We found the practice policies were incomplete. For example, there was no policy regarding the management of high risk medicines.
Other examples	There were regular staff meetings but these were not clearly minuted with actions to be taken in a specific timeframe. There was no evidence of partner meetings, clinical meetings, QOF meetings or MDT meetings.
	Y/N
Staff were able to describe the governance arrangements	NO
Staff were clear on their roles and responsibilities	YES

Any additional evidence

Staff spoken with at Elmdene Surgery, including the branch practices were not aware of the governance arrangements. They were not aware of whether the three surgeries shared the same policies and procedures, and we found that incidents were recorded differently across the sites.

Managing risks, issues and performance

Major incident planning	Y/N
Major incident plan in place	YES
Staff trained in preparation for major incident	YES

Appropriate and accurate information

Question	Y/N
Staff whose responsibilities include making statutory notifications understood what this entails.	YES

Engagement with patients, the public, staff and external partners

Feedback from Patient Participation Group;

Feedback
<p>The practice did not have an active patient participation group.</p> <p>There was a portal on the website where patients were able to leave comments, both positive and negative and the lead GP responded to these.</p> <p>The practice used a texting service to remind patients of their appointment and to obtain feedback. They used the feedback to make improvements to the service provided. After a meeting on 21 May 2018 to review the feedback, the practice introduced new measure such as extending the pre-bookable appointment system from two weeks to four weeks; putting some emergency appointments at the beginning of each morning surgery so that patients who went to the practice to book their appointment did not need to go home again.</p>

Continuous improvement and innovation

Examples of improvements demonstrated as a result of clinical audits in past two years

Audit area	Improvement
None	

Any additional evidence

The practice had no examples of relevant clinical audits carried out in the past two years. An audit on the insertion of intra uterine devices (IUD) between 2009 and 2013 was carried out retrospectively in 2017. However the practice had stopped the insertion of intra uterine coils in 2013. A record keeping audit from February 2017 had no numbers detailed and the yes/no answers had not been marked on the template.

DO NOT DELETE THE NOTES BELOW

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: <http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework (see <https://qof.digital.nhs.uk/>).
- **RCP:** Royal College of Physicians.
- **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. ([See NHS Choices for more details](#)).