

# Care Quality Commission

## Inspection Evidence Table

### Wood Street Health Centre - Dr. Raghav Prasad Dhital (1-542116984)

Inspection date: 20 September 2018

Date of data download: 19 September 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            | Yes |
| Disclosure and Barring Service checks were undertaken where required  | Yes |
| Explanation of any 'No' answers:  |     |

| Recruitment Systems  | Y/N |
|--|-----|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).                                | Yes |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance 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:  |     |

| Safety Records   | Y/N |
|--|-----|
| There was a record of portable appliance testing or visual inspection by a competent person<br>Date of last inspection/Test: 17/01/2018  | Yes |
| There was a record of equipment calibration<br>Date of last calibration: 20/12/2017  | Yes |
| Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals date of ones seen 2012.  | 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 (received specific fire warden training)   | Yes |
| Fire risk assessment<br>Date of completion: 17/02/2017. Review date: 17/02/2019  | Yes |
| <ul style="list-style-type: none"> <li>Actions from the risk assessments were identified and completed.</li> </ul>   | Yes |
| Additional observations: <ul style="list-style-type: none"> <li>The practice rented the premises from NHS England. They shared the premise with other primary care services.</li> <li>The practice had oversight of the risk assessments carried out by the landlord and their own risk assessment for local health and safety risk to staff and patients. However, the landlord had not reviewed the gas safety check since 03/02/2016.</li> <li>Risk assessments were in place for any storage of hazardous substances. The</li> </ul> |     |

|   |     |
|---|-----|
| <p>cleaning company held these. The risk assessments at the practice dated back to 2012. However, staff did not have access to products which had the potential to be harmful to health. In addition, the practice manager informed us that a new cleaning company had recently started.</p> <ul style="list-style-type: none"> <li>• The practice had windows blinds with looped cords, however these were out of children's reach.</li> </ul> |     |
| <p>Health and safety risk assessment and actions<br/>Date of last assessment: 30/08/2018</p>  | Yes |
| <p>Additional comments: two actions highlighted</p> <ul style="list-style-type: none"> <li>• The landlord had carried out a legionella risk assessment on the 27/05/2017, the practice had followed the recommended actions.</li> </ul>   |     |

| Infection control  | Y/N |
|--|-----|
| <p>Risk assessment and policy in place<br/>Date of last infection control audit: 22/02/2018.</p> <ul style="list-style-type: none"> <li>• The practice acted on any issues identified.</li> </ul> <p>Detail: The 22/02/2018 action plan to the infection control audit contained the issues identified, the recommendations, an agreed time frame, and the actions taken. Examples of issues found and actions taken were: -</p> <ul style="list-style-type: none"> <li>• The replacement of non-compliant swan neck taps in clinical rooms. The practice manager had written to the landlord to ask for replacements and was waiting for a response.</li> <li>• Staff with a latex allergy did not have access to the appropriate non-sterile gloves. The practice made non-latex gloves available to all staff for all clinical activities.</li> </ul> | Yes |
| The arrangements for managing waste and clinical specimens kept people safe?   | Yes |
| <p>Explanation of any answers:</p> <ul style="list-style-type: none"> <li>• The practice had a documented clinical waste protocol in place for staff to follow, which was last reviewed December 2017. However, the protocol did not contain the specific information about the practice. For example, the name of waste management company and or the designated day for the waste bins to emptied.</li> <li>• The practice had a waste management contract in place, consignment notices seen for 05/09/2018.</li> </ul>   |     |

## Risks to patients

| Question  | Y/N |
|---|-----|
| There was an effective approach to managing staff absences and busy periods.  | Yes |
| 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.   | No  |
| 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: <ul style="list-style-type: none"> <li>• The service did not have a child oximeter, this monitors a child's oxygen levels and heart rate.</li> <li>• Reception staff were able to tell us about the actions they would take to prioritise a patient with sepsis, however they had not been provided with training.</li> </ul> |     |

## Information to deliver safe care and treatment

| Question  | Y/N |
|---|-----|
| 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 |
| Explanation of any answers: <ul style="list-style-type: none"> <li>• The reception staff scanned relevant documents that the GP. However, due to staff taking annual leave, a two-week backlog had occurred and documents were waiting to be scanned onto the system. We reviewed the documents prior to scanning and found the GP had actioned and recorded in all the patient's notes. During the inspection the staff acted and scanned most of the documents onto the patient notes.</li> </ul> |     |

## 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) (01/07/2017 to 30/06/2018) NHS Business Service Authority - NHSBSA)                                | 0.86     | 0.75        | 0.95            | Comparable with other practices |
| The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2017 to 30/06/2018) (NHSBSA) | 11.2%    | 10.2%       | 8.7%            | Comparable with 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.   | 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 |
| Up to date local prescribing guidelines were in use.   | Yes |
| Clinical staff were able to access a local microbiologist for advice. (Waltham Forest CCG)   | 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.  | Yes |
| The practice had a defibrillator.  | Yes |
| Both were checked regularly and this was recorded.   | 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 answers: <ul style="list-style-type: none"> <li>The practice shared the defibrillator with a practice located in the same premises, both were responsible for the checking of the equipment.</li> <li>The practice held its own oxygen, which staff checked regularly.</li> </ul> |     |

**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       | 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.                            | 3   |
| Number of events that required action                                   | 3   |

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

| Event   | Specific action taken  |
|---|--|
| A GP offered to refer a distressed patient to a secondary care service, the patient became aggressive and police were called, who escorted the patient from the premises. | Following the incident, the patient was removed from the patient list. The reception staff reviewed the actions they had taken and increased their awareness of anticipating and reducing the risk and aggression when responding to patients.   |
| A GP requested for a patient's blood tests to be taken at home in January 2018, the patient's carer informed the practice the bloods had not been taken.                  | The phlebotomist service had received both test request forms but had failed to act on them. The bloods were taken in August 2018. The GP apologised to the patient. The practice has implemented a system to check that the phlebotomist service has responded to all requests for home blood tests |

| Safety Alerts   | Y/N |
|---|-----|
| 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:<br>The most recent safety alerts actioned were in response to:- <ul style="list-style-type: none"> <li>The medicine Esmya. The practice had reviewed the patient register and reviewed the patients who were taking this medicine.</li> <li>The medicine sodium valproate. The practice had reviewed the patient register and reviewed the patients who were taking this medicine.</li> </ul> |     |

| Any additional evidence   |
|---|
| <p>The practice kept a list of concerns that staff or patients had raised where the practice considered the issue may have constituted a duty of candour. The list had 19 incidents and concerns between July 2017 and October 2018, the list included the actions taken and the outcomes.</p> <p>(The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment)</p> |

# 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) (01/07/2017 to 30/06/2018) (NHSBSA) | 1.02                 | 0.69        | 0.83            | Comparable with 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) (QOF)                        | 62.4%  | 75.0%              | 79.5%                  | Variation (negative)            |
| QOF Exceptions   | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                                 |
|  | 3.3% (9)                                       | 14.2%              | 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) | 82.1%  | 79.0%              | 78.1%                  | Comparable with other practices |
| QOF Exceptions   | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                                 |
|  | 3.3% (9)                                       | 7.9%               | 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) | 65.9%  | 75.3%              | 80.1%                  | Variation (negative) |
| QOF Exceptions  | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                      |
|   | 6.3% (17)                                      | 10.9%              | 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, NICE 2011 menu ID: NM23 (01/04/2016 to 31/03/2017) (QOF)          | 81.4%  | 79.1%              | 76.4%                  | Comparable with other practices |
| QOF Exceptions   | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                                 |
|  | 0.4% (1)                                       | 3.7%               | 7.7%                   |                                 |
| Indicator  | Practice                                       | CCG average        | England average        | England comparison              |
| The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF) | 91.9%  | 93.1%              | 90.4%                  | Comparable with other practices |
| QOF Exceptions   | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                                 |
|  | 7.5% (3)                                       | 9.0%               | 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 150/90mmHg or less (01/04/2016 to 31/03/2017) (QOF)   | 82.6%  | 81.8%              | 83.4%                  | Comparable with other practices |
| QOF Exceptions  | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                                 |
|   | 1.8% (9)                                       | 4.0%               | 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) | 72.0%  | 87.1%              | 88.4%                  | Comparable with other practices |
| QOF Exceptions  | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                                 |
|   | 0 (0)  | 8.5%               | 8.2%                   |                                 |

#### Any additional evidence or comments

- The diabetes indicators remained below CCG and national averages; and the exception rate was lower than both the CCG and national average. However, when we spoke with the GPs about this they explained that they felt as if they were “failing” patients if they exception reported them.

For example: -

- 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). The number of patients was 263, the number of patients counted was 164 but the practice only exception reported nine (3.3%). If the practice had the same exception rate as the national average (13.3%), the practice would have exception reported 34 patients. This would have made their total 198 patients, 73.3% of their patient population and comparable to national average of 75%.
- The provider explained the practice had a 15 to 20% turnover of patients annually.
- The provider explained they also had seven patients who were related who refused to take diabetes medication.

## Families, children and young people

| Child Immunisation   |           |             |            |  |
|--|-----------|-------------|------------|--|
| Indicator  | Numerator | Denominator | Practice % | Comparison to WHO target                   |
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2016 to 31/03/2017)(NHS England) | 79        | 92          | 85.9%      | Below 90% minimum (variation negative)     |
| The percentage of 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)  | 95        | 124         | 76.6%      | Below 80% (Significant 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)                                | 91        | 124         | 73.4%      | Below 80% (Significant variation negative) |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2016 to 31/03/2017) (NHS England)   | 90        | 124         | 72.6%      | Below 80% (Significant variation negative) |

### Any additional evidence or comments

- The practice nurse explained they encouraged the parents to bring in children and would follow up children who did not attend. However, they found that younger parents were refusing the vaccines.
- The practice nurse had also followed the new NHS England initiatives to increase immunisation rates.
- At the previous inspection in July 2017, the rates for the vaccines given to under two-year olds ranged from 61% to 84%, the immunisation rates given to five-year olds ranged from 63% to 89%. At this inspection the published results above showed some improvements and the practice provided unpublished data to demonstrate that the April 2018 figures had increase to 94% for under two-year olds and 90% for under five-year olds.
- The provider explained the practice had a 15 to 20% turnover of patients annually.

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 at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2016 to 31/03/2017) (Public Health England)  | 70.9%    | 68.2%       | 72.1%           | Comparable with other practices |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE)   | 60.0%    | 66.1%       | 70.3%           | N/A                             |
| Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE)   | 44.4%    | 46.9%       | 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)   | 77.8%    | 73.8%       | 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)   | 42.9%    | 47.3%       | 51.6%           | Comparable with other practices |
| <b>Any additional evidence or comments</b> <ul style="list-style-type: none"> <li>• The practice nurse sent out up to three reminders to the patients for test and acted opportunistically offering smears when patients attended the practice for other reasons.</li> <li>• The practice nurse kept a record of the smear tests carried out, to check the practice had received the results.</li> <li>• The practice nurse offers appointments each day of the week and once a week between 6pm and 8pm.</li> <li>• Information leaflets about cervical smears were available in different languages.</li> <li>• The practice carried out an audit between February and August 2018, 111 patients had a cervical smear test all had received their results.</li> </ul> |          |             |                 |                                 |

## 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 documented in the record, in the preceding 12 months (01/04/2016 to 31/03/2017) <small>(QOF)</small> | 91.0%  | 92.4%              | 90.3%                  | Comparable with other practices |
| QOF Exceptions  | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                                 |
|   | 4.3% (3)                                       | 6.5%               | 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) <small>(QOF)</small>                          | 92.6%  | 94.1%              | 90.7%                  | Comparable with other practices |
| QOF Exceptions  | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                                 |
|   | 2.9% (2)                                       | 4.9%               | 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) <small>(QOF)</small>  | 83.3%  | 86.2%              | 83.7%                  | Comparable with other practices |
| QOF Exceptions  | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                                 |
|   | 3.2% (1)                                       | 4.3%               | 6.8%                   |                                 |
| Any additional evidence or comments   |  |                    |                        |                                 |

## Monitoring care and treatment

| Indicator                                     | Practice | CCG average | England average |
|---|----------|-------------|-----------------|
| Overall QOF score (out of maximum 559)        | 531      | 538         | 539             |
| Overall QOF exception reporting (all domains) | 3.3%     | 5.8%        | 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) | Yes |

## Helping patients to live healthier lives

| Indicator  | Practice                                       | CCG average        | England average        | England comparison              |
|--|--|--------------------|------------------------|---------------------------------|
| The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF) | 97.1%  | 95.9%              | 95.3%                  | Comparable with other practices |
| QOF Exceptions   | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                                 |
|  | 0.5% (4)                                       | 0.9%               | 0.8%                   |                                 |

## Consent to care and treatment

| Description of how the practice monitors that consent is sought appropriately   |
|---|
| <ul style="list-style-type: none"> <li>The clinical staff described seeking implied and where appropriate consent and adhering to the Mental Capacity Act.</li> <li>The practice does not carry out surgical procedures.</li> </ul> |

# Caring

## Kindness, respect and compassion

| CQC comments cards  |   |
|---|---|
| Total comments cards received   | 2 |
| Number of CQC comments received which were positive about the service | 2 |
| Number of comments cards received which were mixed about the service  | 0 |
| Number of CQC comments received which were negative about the service | 0 |

Examples of feedback received:

| Source                                     | Feedback  |
|--|---|
| CQC comments cards                         | We received two comment cards, both patients stated they felt listened to, and the GPs treated them with concern and sensitivity. Both stated that the practice dealt satisfactorily with their care and treatment.   |
| Patient Participation Group (PPG)          | The representative from the PPG stated the practice staff listened to their concerns and responded. They had seen improvements at the practice, the examples they gave were text messaging patients to remind them of their appointments.   |
| Patients spoken with during the inspection | We spoke with five patients, all stated they were always treated with care and concern by the non-clinical and clinical staff. They commented on the good communication offered by the reception staff.   |
| NHS Choices                                | NHS choices had mixed reviews, the last five comments ranged from three four and five-star reviews. That commented they cannot speak highly enough of this GP, the staff are welcoming and friendly and kind and all the doctors are excellent. Two one-star reviews and concerns about access and referral to other service. The practice had responded to all of the reviews. |
| Friends and Family Survey                  | From July 2017 to August 2018 the questionnaire asked how likely the patient was to recommend the service. Ninety-one responses were received and 82 patients said they were extremely likely or likely to recommend the service. The nine other patients said they were unsure about whether they would recommend or not.  |

## National GP Survey results

**Note:** The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology has changed in 2018. This means that we cannot be sure whether the change in scores was due to the change in methodology, or was due to a genuine change in patient experience.

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 5820                     | 408              | 102              | 25%                   | 1.75%                    |

| Indicator   | Practice | CCG average | England average | England comparison              |
|---|----------|-------------|-----------------|---------------------------------|
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)                   | 89.4%    | 82.8%       | 89.0%           | Comparable with other practices |
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018) | 82.2%    | 79.7%       | 87.4%           | Comparable with other practices |
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)                              | 92.3%    | 92.9%       | 95.6%           | Comparable with other practices |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)   | 82.7%    | 77.6%       | 83.8%           | Comparable with other practices |
| <b>Any additional evidence or comments</b>  |          |             |                 |                                 |

| Question  | Y/N |
|---|-----|
| The practice carries out its own patient survey/patient feedback exercises. | No  |

| Any additional evidence  |
|--|
| <ul style="list-style-type: none"> <li>The practice responds and monitors the information from the friends and family survey, the national GP survey, and from the patient participation group.</li> </ul> |

## Involvement in decisions about care and treatment

Examples of feedback received:

| Source                     | Feedback   |
|----------------------------|--|
| Interviews with patients.  | We spoke with six patients who all stated they were informed about their treatment and care. |
| Two patient comment cards. | Both stated they were informed and satisfied with their 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 during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018) | 91.2%    | 90.2%       | 93.5%           | Comparable with other practices |
| <b>Any additional evidence or comments</b>   |          |             |                 |                                 |

| 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 leaflets were available in easy read format.  | No  |
| Information about support groups was available on the practice website.   | Yes |



| Carers   | Narrative  |
|--|--|
| Percentage and number of carers identified           | 84 patients on the practice register, which was 1.4% of the patient population.                              |
| How the practice supports carers                     | The practice referred carers to the local support services. They also offered immunisation against flu.      |
| How the practice supports recently bereaved patients | The practice referred bereaved patients to counselling services and when appropriate sent a condolence card. |

| Any additional evidence |
|-------------------------|
|                         |

### Privacy and dignity

| Question   | Y/N |
|--|-----|
| 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 | Staff spoke quietly at the reception desk, a private area was available if a patient wanted to speak confidentially. |

| 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 |               |
|------------------------|---------------|
| Day                    | Time          |
| Monday                 | 8am to 6:30pm |
| Tuesday                | 8am to 6:30pm |
| Wednesday              | 8am to 6:30pm |
| Thursday               | 8am to 1pm    |
| Friday                 | 8am to 6:30pm |

| Appointments available |                              |
|------------------------|------------------------------|
| Monday                 | 9:30am to 1pm and 2pm to 4pm |
| Tuesday                | 9:30am to 1pm and 2pm to 8pm |
| Wednesday              | 9:30am to 1pm and 2pm to 6pm |
| Thursday               | 9:30am to 12:30pm            |
| Friday                 | 9:30am to 1pm and 2pm to 6pm |

| 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 receptionists referred the request to the GPs who would review the request and telephone the patient to arrange the home visit. |     |

## National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 5820                     | 408              | 102              | 25%                   | 1.75%                    |

| Indicator  | Practice | CCG average | England average | England comparison              |
|--|----------|-------------|-----------------|---------------------------------|
| The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs | 92.7%    | 92.3%       | 94.8%           | Comparable with other practices |

| Indicator                                  | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------|
| were met (01/01/2018 to 31/03/2018)        |          |             |                 |                    |
| <b>Any additional evidence or comments</b> |          |             |                 |                    |

## Timely access to the service

National GP Survey results

| Indicator   | Practice | CCG average | England average | England comparison              |
|---|----------|-------------|-----------------|---------------------------------|
| The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018) | 71.8%    | 61.4%       | 70.3%           | Comparable with other practices |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)                             | 64.4%    | 63.7%       | 68.6%           | Comparable with other practices |
| The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)                    | 63.2%    | 65.2%       | 65.9%           | Comparable with other practices |
| The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)                     | 77.4%    | 69.8%       | 74.4%           | Comparable with other practices |
| <b>Any additional evidence or comments</b>  |          |             |                 |                                 |

Examples of feedback received from patients:

| Source                                     | Feedback  |
|--|---|
| CQC comments cards,                        | We received two comment cards, both did not raise access as an issue.   |
| Patient Participation Group (PPG)          | The representative from the PPG did not raise access as an issue but provided examples of where the practice had made improvements to access, such as a website, online prescriptions and text messaging prior to an appointment. |
| Patients spoken with during the inspection | We spoke with five patients, all stated they can get an appointment or a home visit on the same day. The reception staff informed them if appointments running late, and all had enough time during the consultation.             |
| NHS Choices                                | A mixed response, the last five comments ranged from three four and five-star   |

|                           |  |
|---------------------------|--|
|                           | reviews that were positive and two one-star reviews and concerns about access and referral to other service. The practice had responded to all the reviews.  |
| Friends and Family Survey | From July 2017 to August 2018 the questionnaire asked how likely the patient was to recommend the service. Ninety-one responses were received and 82 patients said they were extremely likely or likely to recommend the service. The nine other patients said they were unsure about whether they would recommend or not. |

## Listening and learning from complaints received

| Complaints  | Y/N |
|---|-----|
| Number of complaints received in the last year.   | 2   |
| Number of complaints we examined  | 2   |
| Number of complaints we examined that were satisfactorily handled in a timely way   | 2   |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman   | 0   |
| <b>Additional comments:</b>   |     |
| <ul style="list-style-type: none"> <li>The practice manager investigated and responded to general complaints, the providers responded to clinical complaints.</li> <li>The complaints procedure did not contain sufficient information about how to make a complaint or a review date. For example, the name of the practice manager, whether the complaint would be investigated and who by and the how long the practice would take to respond to the complaint.</li> </ul> |     |

| Example of how quality has improved in response to complaints   |
|---|
| <ul style="list-style-type: none"> <li>Following a complaint about an incorrect repeat prescription. The complaint was investigated and discussed at a practice meeting and staff reminded to be vigilant when responding to requests.</li> </ul> |

| Any additional evidence   |
|---|
| <ul style="list-style-type: none"> <li>The practice kept a list of concerns that staff or patients had raised where the practice considered it may have constituted a duty of candour. This had 19 incidents and concerns between July 2017 and October 2018, the list included the actions taken and the outcomes.<br/>(The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).</li> </ul> |

## Well-led

## Leadership capacity and capability

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

The leaders discussed the challenges they faced and how they hoped to respond to them.

## Vision and strategy

## Practice Vision and values

Staff described the practice as a family practice, where the main aim of the service was to provide a quality service to patients.

## Culture

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

- Staff stated they felt respected, supported, and valued and worked well as a team.
- The complaints and significant events demonstrated openness and honesty in their responses.
- All staff received regular annual appraisals in the last year.
- The provider was aware of the requirements of the duty of candour.

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

| Source  | Feedback   |
|---|--|
| Staff spoken to on the day of the inspection. | Commented they worked well as a team and felt supported by managers. |

## Governance arrangements

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

|   |  |
|---|--|
| Practice specific policies                              | The practice procedures and policies sometimes lacked the necessary information and specific information about the practice. For example, the complaint procedure and the waste management policy.   |
| Other examples  | Due to staff annual leave the system to ensure the scanning of patient documents had a two week backlog. This meant the GPs may not have had the information available to provide care and treatment. However, on the day of the inspection the majority of the backlog was dealt with by staff. |
|   |  |
|   | Y/N  |
| Staff were able to describe the governance arrangements | Yes  |
| Staff were clear on their roles and responsibilities    | Yes  |

| Any additional evidence  |
|--|
| <ul style="list-style-type: none"> <li>The practice held monthly clinical meetings that were attended by the doctors.</li> <li>Multi-disciplinary team meeting were held monthly.</li> <li>Practice meetings for all staff were held regularly.</li> </ul> |

## Managing risks, issues and performance

| Major incident planning                         | Y/N |
|---|-----|
| Major incident plan in place                    | Yes |
| Staff trained in preparation for major incident | Yes |

Examples of actions taken to address risks identified within the practice

| Risk       | Example of risk management activities  |
|------------|--|
| Succession | The provider had commenced making plans for succession should anyone retire. |

## Appropriate and accurate information

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

| Any additional evidence   |
|---|
| <ul style="list-style-type: none"> <li>The practice had two boxes of unlocked patient records in the reception office, that was shared with other practices. The provider explained that the practice had ordered further lockable cabinets.</li> </ul> |

## Engagement with patients, the public, staff and external partners

### Feedback from Patient Participation Group;

| Feedback   |
|--|
| The patient participation group had 11 members and met four times a year. The PPG reported that they had a good relationship with the practice staff who listened to their ideas for improvement. They reported the practice was open and honest and felt they met the needs of the local population. They explained the improvements that had occurred were development of the website, text messaging about appointments and online prescription services. |

## Continuous improvement and innovation

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

| Audit area | Improvement |
|------------|-------------|
|------------|-------------|

|  |   |
|--|---|
| April 2018, self-monitoring of blood glucose and nine key processes. | Review of the improvements for patients who self-monitor their blood glucose.   |
| Methotrexate and Sulfasalazone audit 2017 with a re-audit in 2018.   | <p>The monitoring of Methotrexate and Sulfasalazone was a challenge for the practice to monitor, due to the shared care arrangements with hospital trusts. 100% of all patients on these medications should have had a blood test check at least three months maximum prior to a repeat prescription or as advised by the hospital clinic.</p> <p>In 2017 and 2018, the audit demonstrated all patients receiving methotrexate and Sulfasalazone had the correct blood tests.</p> |

### Any additional evidence

- The practice had displayed their CQC ratings on their website.

#### Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as comparable, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as comparable to other practices.

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

The following language is used for showing variation:

|   | Variation Band                   | Z-score threshold |
|---|----------------------------------|-------------------|
| 1 | Significant variation (positive) | $Z \leq -3$       |
| 2 | Variation (positive)             | $-3 < Z \leq -2$  |
| 3 | Comparable to other practices    | $-2 < Z < 2$      |
| 4 | Variation (negative)             | $2 \leq Z < 3$    |
| 5 | Significant variation (negative) | $Z \geq 3$        |
| 6 | No data                          | Null              |

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

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

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](#)).