

Care Quality Commission

Inspection Evidence Table

Westbourne Surgery (1-4303601917)

Inspection date: Wednesday 26 September 2018

Date of data download: 13 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(s) of staff for safeguarding processes and procedures. | Y |
| Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Y |
| Policies were in place covering adult and child safeguarding. | Y |
| Policies were updated and reviewed and accessible to all staff. | Y |
| Partners and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs) | Y |
| Information about patients at risk was shared with other agencies in a timely way. | Y |
| Systems were in place to highlight vulnerable patients on record. There was a risk register of specific patients | Y |
| Disclosure and Barring Service checks were undertaken where required | Y |
| Explanation of any 'No' answers: N/A | |

| Recruitment Systems | Y/N |
|--|-----|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Y |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role. | Y |
| Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | Y |
| Staff who require medical indemnity insurance had it in place | Y |
| <p>Explanation of any answers:</p> <p>One of the staff files we looked at did not have a photo ID check. The practice manager reassured us after the inspection that all staff files had been updated with a copy of the NHS smart card.</p> | |

| Safety Records | Y/N |
|---|--------------------------------|
| There was a record of portable appliance testing or visual inspection by a competent person Date of last inspection/Test: | Y Dec 17 |
| There was a record of equipment calibration Date of last calibration: | Y Dec 17 |
| Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals | Y |
| Fire procedure in place | Y |
| Fire extinguisher checks | Y |
| Fire drills and logs | Y |
| Fire alarm checks | Y |
| Fire training for staff | Y |
| Fire marshals | Y |
| Fire risk assessment Date of completion | Y Dec 17 |
| Actions were identified and completed. Practice has improved signage on the exits to the building. | Y |
| Additional observations: A named fire marshal was not needed at the practice (according to fire brigade guidance). A risk assessment and a fire drill was undertaken. Fire drill was due to be carried out on 1 October 2018. | Y |
| Health and safety Premises/security risk assessment? Date of last assessment: | Y Every month. Sept 2018 |
| Health and safety risk assessment and actions Date of last assessment: | Y Every month. Sept 2018 |
| Additional comments: Sharps bins and hazardous waste bags were collected weekly, under an annual contract running until December 2018 when it was due to be renewed. | |

| Infection control | Y/N |
|---|------------------------------------|
| <p>Risk assessment and policy in place</p> <p>Date of last infection control audit: The practice acted on any issues identified.</p> <p>Detail: Monthly assessments were undertaken using an audit tool.</p> <p>Examples of actions: Pedal bin liners replacement. Shelves to be dust free. (Dust identified in June 2018 walk round). Pillow cases on couches to be single use from now on. We saw evidence that pillow cases were single use in the clinical rooms.</p> | <p>Y</p> <p>June 2018</p> <p>Y</p> |
| <p>The arrangements for managing waste and clinical specimens kept people safe?</p> | <p>Y</p> |
| <p>Explanation of any answers: Weekly removal of clinical waste into a locked outside bin was inspected by us.</p> | |

| Any additional evidence |
|---|
| <p>Fire safety audit completed by Huddersfield Fire and Rescue Service February 2018.</p> <p>The practice had undertaken a Control of Substances Hazardous to Health (COSHH) risk assessment with an external company in February 2018.</p> |

Risks to patients

| Question | Y/N |
|--|-----|
| There was an effective approach to managing staff absences and busy periods. | Y |
| Comprehensive risk assessments were carried out for patients. | Y |
| Risk management plans were developed in line with national guidance. | Y |
| Staff knew how to respond to emergency situations. | Y |
| 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. | Y |
| In addition, there was a process in the practice for urgent clinician review of such patients. | Y |
| The practice had equipment available to enable assessment of patients with presumed sepsis. | Y |
| 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. | Y |
| Explanation of any answers: A two month in advance rota was developed and agreed with staff. Regular reviews of staffing levels were carried out, and staff increased their hours on a temporary basis when necessary. | |

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. | Y |
| Referral letters contained specific information to allow appropriate and timely referrals. | Y |
| Referrals to specialist services were documented. | Y |
| The practice had a documented approach to the management of test results and this was managed in a timely manner. | Y |
| 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. | Y |
| Explanation of any answers: All referrals were logged on the clinical IT system and followed up on a monthly basis. Every staff member had been trained on doing emergency referrals, so there was always someone available to do this. | |

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) | 1.31 | 1.07 | 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) | 6.9% | 7.3% | 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. | Y |
| Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions). | Y |
| Prescriptions (pads and computer prescription paper) were kept securely and monitored. | Y |
| 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. | Y |
| The practice monitored the prescribing of controlled drugs. (For example audits for unusual prescribing, quantities, dose, formulations and strength). | Y |
| There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. | Y |
| 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. | N/A |
| Up to date local prescribing guidelines were in use. | Y |
| Clinical staff were able to access a local microbiologist for advice. | Y |
| For remote or online prescribing there were effective protocols in place for identifying and verifying the patient in line with General Medical Council guidance. | Y |
| The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held. | Y |
| The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases. | Y |
| There was medical oxygen on site. | Y |
| The practice had a defibrillator. | Y |
| Both were checked regularly and this was recorded. | Y |

| | |
|---|---|
| Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use. | Y |
| Explanation of any answers: Most staff were trained on checking and logging fridge temperatures as well as cold chain training. | |

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 | Y |
| Staff understood how to report incidents both internally and externally | Y |
| There was evidence of learning and dissemination of information | Y |
| Number of events recorded in last 12 months. | 1 |
| Number of events that required action | 1 |

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

| Event | Specific action taken |
|------------------|--|
| Patient Symptoms | Staff reminded that immediate action to be taken when a patient presents with potential serious symptoms. |
| Communication | Only relevant information as specified by the GP to be given to the patient by reception staff while giving out the results to patients. |
| Data Accuracy | Checking that correct information was put in the pathology forms. |

| Safety Alerts | Y/N |
|---|-----|
| There was a system for recording and acting on safety alerts | Y |
| Staff understand how to deal with alerts | Y |
| Comments on systems in place: Practice discussed safety alerts at team meetings which were held every other month. A nominated person received safety alerts, medications management team from the CCG visit the practice twice a month. Practice manager talked with staff and an actions log was created. This included which alert had been actioned. Searches were conducted on the clinical system and appropriate action was taken on all occasions. | |

| Any additional evidence |
|---|
| Practice Manager (PM) was asked to join the Practice Managers Reference Group. Seven managers |

out of 37 practices attended this forum in the Huddersfield area. PM was setting up PLT (protected learning time) training for all practices in the area. CCG chaired the meetings which were held monthly. We saw the agenda for the 27 September meeting.

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) | 0.93 | 0.83 | 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) | 84.8% | 79.8% | 79.5% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 12.1% (19) | 9.5% | 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) | 76.9% | 75.6% | 78.1% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 8.9% (14) | 8.0% | 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) | 80.3% | 76.6% | 80.1% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 6.4% (10) | 13.8% | 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) | 93.6% | 78.4% | 76.4% | Significant Variation (positive) |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 1.7% (4) | 5.6% | 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) | 94.7% | 90.9% | 90.4% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 3.4% (2) | 9.5% | 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) | 89.2% | 83.2% | 83.4% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 2.5% (11) | 3.4% | 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) | 90.0% | 86.4% | 88.4% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 9.1% (5) | 9.2% | 8.2% | |
| Any additional evidence or comments N/A | | | | |

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) | 34 | 34 | 100.0% | Met 95% WHO based target (significant variation positive) |
| 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) | 42 | 44 | 95.5% | Met 95% WHO based target (significant variation positive) |
| 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) | 42 | 44 | 95.5% | Met 95% WHO based target (significant variation positive) |
| 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) | 42 | 44 | 95.5% | Met 95% WHO based target (significant variation positive) |
| Any additional evidence or comments | | | | |
| N/A | | | | |

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) | 76.0% | 77.0% | 72.1% | Comparable with other practices |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE) | 71.5% | 67.2% | 70.3% | N/A |
| Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE) | 67.4% | 59.4% | 54.6% | 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) | 90.9% | 64.9% | 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) | 25.0% | 54.1% | 51.6% | Comparable with other practices |
| Any additional evidence or comments N/A | | | | |

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) (QOF) | 93.8% | 91.7% | 90.3% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 11.1% (2) | 9.5% | 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) (QOF) | 100.0% | 90.4% | 90.7% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 16.7% (3) | 7.2% | 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) | 75.9% | 86.5% | 83.7% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 3.3% (1) | 6.3% | 6.8% | |
| Any additional evidence or comments | | | | |
| The practice had analysed their QOF exception reporting and provided a narrative. All QOF exception reporting was subject to clinical oversight. Practice GPs would review all of these patients and clinical decisions had been made on an individual basis according to their needs. | | | | |

Monitoring care and treatment

| Indicator | Practice | CCG average | England average |
|---|----------|-------------|-----------------|
| Overall QOF score (out of maximum 559) | 558 | 536 | 539 |
| Overall QOF exception reporting (all domains) | 4.6% | 5.6% | 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) | 97.6% | 95.7% | 95.3% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 0.5% (4) | 0.6% | 0.8% | |

Consent to care and treatment

| Description of how the practice monitors that consent is sought appropriately |
|--|
| <p>Every referral had a form that was signed and recorded. Consent was coded on the clinical system. Consent policy seen.</p> <p>Consultations had been created to facilitate consent discussed and obtained for all procedures. Written consent was recorded for all invasive procedures.</p> <p>An up to date consent policy was in place.</p> <p>For patients not able to give informed consent, there was a policy in place, for example, a link with the local learning disability nursing team, both for primary and secondary care.</p> |

| Any additional evidence |
|---|
| <p>We were told by staff members that Westbourne surgery treated all patients with dignity and respect irrespective of caste, creed or gender.</p> <p>All the receptionists were chaperone trained and understood what this meant to both the patient and GP. The practice offered the chaperone service to both male and female patients.</p> <p>Patient records were always treated with confidentiality and respect with processes in place to that effect. Patients were asked for their consent for referrals or correspondence to third parties this was then recorded in their electronic records.</p> |

Caring

Kindness, respect and compassion

| CQC comments cards | |
|---|----|
| Total comments cards received | 36 |
| Number of CQC comments received which were positive about the service | 36 |
| 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 |
|--------------------------|---|
| Patient engagement event | 524 responses from a patient engagement event on 30 July 2018. Appointment booking was scored highly in the survey. 78% were happy with the appointment system. |

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 |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 3763 | 290 | 118 | 40.7% | 3.1% |

| 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) | 89.9% | 91.0% | 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) | 91.0% | 89.4% | 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) | 95.6% | 96.9% | 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) | 93.1% | 86.9% | 83.8% | Comparable with other practices |
| Any additional evidence or comments N/A | | | | |

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

| Date of exercise | Summary of results |
|------------------|--------------------|
| Sept 2018 | See page 23. |

| Any additional evidence |
|--|
| Friends & Family test (July, August, September 2018) showed that the patients who made a response (36 returns) were recording positive comments. |

Involvement in decisions about care and treatment

Examples of feedback received:

| Source | Feedback |
|---------------------------|----------|
| Interviews with patients. | N/A |

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) | 98.8% | 94.5% | 93.5% | Comparable with other practices |
| Any additional evidence or comments | | | | |

| Question | Y/N |
|---|-----|
| Interpretation services were available for patients who did not have English as a first language. | Y |
| Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations. | Y |
| Information leaflets were available in easy read format. | Y |
| Information about support groups was available on the practice website. | Y |

| Carers | Narrative |
|--|---|
| Percentage and number of carers identified | 64 which was just under 2% of the practice list. |
| How the practice supports carers | <p>Patients were identified as carers at registration or through staff interactions. All carers were offered flu vaccinations, and home visits were undertaken for all housebound patients, when a carer requested this. Signposting by staff took place to highlight the services available as well as helping organise transport for appointments.</p> <p>'Carers count' information was available on the TV screen in reception. There was a carers count meeting in July 2018.</p> <p>One staff member was responsible for carer referrals.</p> <p>The practice included information in the quarterly newsletter.</p> |
| How the practice supports recently bereaved patients | Send condolence cards. (Birthday cards for patients aged 100 years or older were also sent). |

| Any additional evidence | | | |
|--|------------------------|-------------|-----|
| <p>A patient regularly visited the practice and staff talked with them and walked them home often. The practice received a large amount of Christmas gifts which were raffled to support local charities.</p> <p>A recent carers survey showed that: -</p> | | | |
| Carers | Population | Respondents | |
| | Greater Huddersfield % | No. | % |
| No. of Hours worked as a carer | | 64 | 13% |
| 0-19 hours | 6.92 | | |
| 20-49 | 1.36 | | |
| 50+ | 2.22 | | |

Privacy and dignity

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

| | Narrative |
|--|---|
| Arrangements to ensure confidentiality at the reception desk | A new privacy screen/window was installed in reception in September 2018. This now has reduced the risk of conversations being overheard. |

| Question | Y/N |
|---|-----|
| Consultation and treatment room doors were closed during consultations. | Y |
| A private room was available if patients were distressed or wanted to discuss sensitive issues. | Y |

Examples of specific feedback received:

| Source | Feedback |
|-------------------|--------------------------------------|
| CQC Comment Cards | "The surgery is brilliant". |
| Patient feedback | "The doctors are lovely and caring". |

Responsive

Responding to and meeting people's needs

| Practice Opening Times | |
|------------------------|-----------|
| Day | Time |
| Monday | 8AM – 6PM |
| Tuesday | 8AM – 6PM |
| Wednesday | 8AM – 6PM |
| Thursday | 7AM – 6PM |
| Friday | 8AM – 6PM |

| | |
|------------------------|---|
| Appointments available | |
| | Mon 8.20AM until 16:50PM Tues 8:30AM until 17:30PM Wed 8:10AM until 17:10PM Thurs 8:30AM until 17:10PM Fri 8:30AM until 17:10PM |
| Extended hours opening | |
| | Thurs 7AM until 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 | Y |
| If yes, describe how this was done | |
| <p>The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. The receptionist received the request, put the information on the clinical system, a summary was printed out to take with visit.</p> <p>Usually one or two 2 a day, but maximum six home visits were undertaken per day.</p> | |

National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 3763 | 290 | 118 | 40.7% | 3.1% |

| Indicator | Practice | CCG average | England average | England comparison |
|-----------|----------|-------------|-----------------|--------------------|
|-----------|----------|-------------|-----------------|--------------------|

| 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 were met (01/01/2018 to 31/03/2018) | 99.5% | 96.0% | 94.8% | Comparable with other practices |
| Any additional evidence or comments N/A | | | | |

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) | 72.7% | 73.1% | 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) | 76.8% | 69.6% | 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) | 66.5% | 66.3% | 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) | 79.3% | 77.3% | 74.4% | Comparable with other practices |
| Any additional evidence or comments N/A | | | | |

Examples of feedback received from patients:

| Source | Feedback |
|---|---|
| Report of findings on the engagement for Westbourne Surgery September 2018 | <p>524 patients completed the survey. Highlights of the results: -</p> <ul style="list-style-type: none"> • Good care and treatment 96% • Being able to book an appointment 93% • A clean and safe place 87% • Location of surgery 74% • Getting to the location easily 65.5% • Adequate Parking 64% • Appropriate Waiting area 64% • Nearby pharmacy/chemist 53% • Easy access to the building 53% • Access to public transport from the surgery 41% |

Listening and learning from complaints received

| Complaints | Y/N |
|--|-----|
| Number of complaints received in the last year. | 1 |
| Number of complaints we examined | 1 |
| Number of complaints we examined that were satisfactorily handled in a timely way | 1 |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman | 0 |
| Additional comments: | |
| <p>All complaints (if received) would be discussed with the GPs and practice manager every month as a regular agenda item at the practice meeting. This enabled the practice to learn lessons from complaints, check for trends and if appropriate make changes to procedures. Complaint we looked at had been fully investigated and discussed with the individual member of staff involved and any training needs had been addressed. Patients will always be offered the opportunity to discuss complaints with the practice manager in person.</p> <p>We saw examples which showed the duty of candour had been complied with, for example where an error had been made on a patient's prescription which had not had any negative effects, the practice had notified the patient involved and apologised for the error.</p> | |

| Example of how quality has improved in response to complaints |
|---|
| <p>Patients had complained about overhearing conversations in reception. The practice had acted upon this feedback. A new glass screen was installed in September 2018.</p> |

| Any additional evidence |
|-------------------------|
| N/A |

Well-led

Leadership capacity and capability

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

The partners worked closely with the practice manager. The senior partner chaired the practice meetings and had time set aside each week for meetings with the practice manager.

The practice had introduced document management, working to agreed protocols, with administrative staff reviewing clinical correspondence and reducing administrative workload for the GPs.

The practice had adapted to clinical staff recruitment challenges as it had experienced a GP partners retirement since the last inspection. For example, the practice had recruited a practice nurse who had previously been employed by the CCG.

Any additional evidence

Aims and objectives: The practice aimed to provide holistic care to all patients and promote physical and mental wellbeing by motivational interventions. The practice stated that they were very personal in their approach, very patient centred and indiscriminate in approach.

Vision and strategy

Practice Vision and values

The practice had a vision and values in place which emphasised the importance of providing services that everyone could be proud of. The practice valued its working team and partnerships with outside agencies. The practice was committed to providing personalised care and continuity of care for patients. The practice had been responsive to feedback and responding positively to changes within the practice and wider NHS.

Culture

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

The practice worked proactively with the Community Matron and Palliative Care nurse to support end of life care planning and hospital admission prevention. The practice held monthly Gold Standard Framework meetings to discuss patients on its Palliative care register.

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

| Source | Feedback |
|------------------|---|
| Staff & Patients | Privacy screen in reception |
| Staff member | Staff we spoke with told us they felt supported by the management team at the practice, involved in decisions and listened to during meetings. Staff told us there was an open culture of transparency and a safe learning environment. |

| Any additional evidence |
|---|
| The practice produced a quarterly newsletter with updates on practice news, health promotion and staff changes. |

Governance arrangements

| Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care. | |
|--|--|
| Practice specific policies | Zero tolerance. |
| Practice specific policies | Policies were in place and available on the shared drive for all members of staff. |
| | |
| | Y/N |
| Staff were able to describe the governance arrangements | Y |
| Staff were clear on their roles and responsibilities | Y |

| Any additional evidence |
|--|
| Staff said they felt able to raise concerns or ideas and added that they felt confident and explained that the leadership team listened and acted on their suggestions. Staff felt included in the day to day running of the practice. |

Managing risks, issues and performance

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

Examples of actions taken to address risks identified within the practice

| Risk | Example of risk management activities |
|---------------------------|---|
| Confidential Information | Privacy screen installed at reception in September 2018 |
| Access to Clinical system | A dedicated practice laptop at the practice manager's home enabled access to the practice systems at all times. |
| | |

| Any additional evidence |
|--|
| The provider had undertaken a number of risk assessments relevant to the provision of clinical care, including infection control and premises risk assessments. Recommendations from risk assessments had been actioned. |

Appropriate and accurate information

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

Any additional evidence

The practice handbook was updated as soon as new procedures were implemented and had been made more user-friendly. Communication was made by notification through the IT system and sent out to all staff when an update had been made.

Engagement with patients, the public, staff and external partners

Feedback from Patient Participation Group;

Feedback

We reviewed minutes from April and June 2018. Nine members of the PPG group attended the meetings and feedback included, reception, pharmacy engagement and training of staff.

Any additional evidence

After the inspection we contacted members of the PPG. They provided us with positive feedback about the practice, described excellent access to the GP and the practice manager.

Continuous improvement and innovation

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

| Audit area | Improvement |
|-----------------|---|
| Palliative care | In a local Hospice, improved engagement for patients with health professionals. |

Any additional evidence

Practice Protected Learning Time (PLT) sessions were held weekly, all staff were offered these opportunities to learn and keep up to date with latest best practice procedures.

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](#)).