

# Care Quality Commission

## Inspection Evidence Table

**Dr Samuel Bhasme (1-509665027)**

**Inspection date: 9 October 2018**

**Date of data download: 28 September 2018**

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

Safety systems and processes	
There was up to date written guidance available for staff to follow to help them identify, report and manage any significant events.	Yes
There was a lead member of staff for safeguarding processes and procedures.	Yes
Policies covering adult and child safeguarding were accessible to all staff. They clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare.	No
Staff were trained to appropriate levels for their role (for example level three for GPs) and knew how to identify and report concerns.	No
The practice worked in partnership with other agencies to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. Information about patients at risk was shared with other agencies in a timely way.	Yes
Reports and learning from safeguarding incidents were available to staff.	Yes
A notice in the practice advised patients that chaperones were available if required.	Yes
Staff who acted as chaperones were trained for the role	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required	Yes
Additional evidence or comments	
<p>The practice's vulnerable adults policy did not contain details of who to contact if staff had concerns about a patient's welfare. After the inspection the practice wrote to us and provided an updated copy of their safeguarding vulnerable adults policy that contained details of who to contact if staff had concerns about a patient's welfare.</p> <p>We looked at the training records of five members of staff. We found that there was no record of one clinical member of staff's safeguarding vulnerable adults training and that another non-clinical member of staff was not up to date with safeguarding children training.</p>	

Recruitment Systems	
Recruitment checks were carried out in accordance with regulations.	Yes
Staff vaccination was maintained in line with current Public Health England guidance and if relevant to role.	Yes
There were systems to help ensure the registration of clinical staff was checked and regularly monitored.	Yes
Relevant staff had medical indemnity insurance.	Yes

Safety Records	
There was an up to date fire risk assessment that incorporated an action plan to address issues identified.	Yes
The practice had a fire evacuation plan.	Yes
Records showed fire extinguishers were maintained in working order.	Yes
Records showed that the practice carried out fire drills.	No
Records showed the fire alarm was tested regularly.	Yes
Records showed the battery-operated smoke detectors were tested weekly.	Yes
The practice had a designated fire marshal who was up to date with fire marshal training.	No
Staff were up to date with general fire safety training.	Yes
All electrical equipment was checked to help ensure it was safe to use.	Yes
All clinical equipment was checked and where necessary calibrated to help ensure it was working properly.	Yes
Additional evidence or comments	
<p>At our inspection on 11 July 2017 we found that the practice's fire risk assessment document was not dated and did not carry any information that identified it as pertaining to the practice. The document contained recommendations of actions required to improve fire safety and reduce risk. The recommendations indicated that further controls were required to be carried out but did not indicate a timeframe by which these were to be implemented.</p> <p>At our inspection on 20 March 2018 we found that the practice had a fire risk assessment dated 4 December 2017. The risk assessment contained an action plan to address some of the identified issues. The practice did not have a fire alarm system but did have smoke detectors fitted. However, the fire risk assessment document stated that fire could not be easily detected and the fire alarm could not be raised in all parts of the premises. Additionally, there were no records to demonstrate that the smoke detectors were tested regularly or that the practice had carried out any fire drills.</p> <p>At our inspection on 19 June 2018 we saw that a new fire alarm system had been installed in the practice. Staff told us that the new fire alarm system, that included some hard-wired smoke detectors, was tested on a regular basis and records confirmed this. Staff told us that the existing battery-operated smoke detectors were also checked on a regular basis. However, there were no records to confirm this. After our inspection the provider wrote to us and told us that the battery-operated smoke detectors would emit a beeping sound if the battery was low on power and therefore regular checking was unnecessary. Records showed that the practice had conducted a fire drill on 16 April 2018. Staff told us that the fire risk assessment dated 4 December 2017 had not been updated since our last inspection or since the installation of the new fire alarm system.</p> <p>At our inspection on 9 October 2018 we found that the practice had carried out a fire risk assessment on 26 June 2018. However, the fire risk assessment document indicated that all doors on escape routes opened in the direction of travel. We saw that this was not correct and observed that the exit doors at the front and rear of the practice opened in the opposite direction to the direction of travel. Staff told us that the feasibility of refitting these doors to open outwards was being considered.</p> <p>Staff told us that the door at the front of the practice building was unlocked at the start of every working day. However, we saw that this door was bolted shut at the top and bottom. Staff told us that if someone needed to exit the premises in an emergency through this door they would need to undo both bolts. This would not be possible for adults or children who were unable to reach the bolt at the top of the door. This</p>	

issue had not been identified by the fire risk assessment.

The fire risk assessment document indicated that the practice had established safe assembly points away from the building. This was correct for the safe assembly point at the rear of the building.

However, the fire risk assessment document indicated that the assembly point at the front of the building was the front garden. We saw that the front garden was small and directly adjacent to the practice building. This assembly point was not away from the building.

The fire risk assessment document indicated that the alternative way of escaping from upper floors if a main stairway was blocked was through large windows. We asked staff to show us which windows on the first floor were the designated alternative fire escape if the main stairway was blocked. The window they showed us opened onto the sloping roof of the building's ground floor. This alternative fire escape was not signposted nor lit with emergency lighting.

Staff told us that battery operated smoke detectors were now being checked on a regular basis and records confirmed this.

Staff told us and records confirmed that the fire marshal was not up to date with fire marshal training nor that training had been booked to be carried out at a future date. We saw records to show that the fire marshal was on a waiting list for fire marshal training. However, there was no indication of when the training would take place.

Infection prevention and control	
We observed the premises to be clean and all areas accessible to patients were tidy.	Yes
There was a lead member of staff for infection prevention and control who liaised with the local infection prevention teams to keep up to date with best practice.	Yes
There was an up to date infection prevention and control policy.	Yes
There was an up to date infection prevention and control audit that incorporated an action plan to address issues identified.	Yes
Relevant staff were up to date with infection prevention and control training.	Yes
The arrangements for managing waste kept people safe.	Yes
Additional evidence or comments	
<p>At our inspection on 11 July 2017 we found that the practice did not have a lead member of staff for infection prevention and control who liaised with the local infection prevention teams to keep up to date with best practice.</p> <p>At our inspection on 20 March 2018 we found that the practice had appointed a lead member of staff for infection prevention and control. However, they had not received training for the role.</p> <p>At our inspection on 9 October 2018 we found that the practice's lead member of staff for infection prevention and control had attended relevant level three training for the role. They told us that they were liaising with the local infection prevention teams to keep up to date with best practice.</p> <p>The practice had an infection control policy that had been reviewed on 1 June 2018. However, staff told us that the local infection prevention team leader had advised the practice that their infection control policy was insufficient. We saw that the practice's infection control policy was incomplete. For example, sections of the policy read as follows:</p> <ul style="list-style-type: none"> <li>• [Insert name] will be responsible for the maintenance of personal protective equipment and the provision of personal cleaning supplies within clinical areas.</li> <li>• [Insert name] will be responsible for the maintenance of the provision of personal cleaning supplies within non-clinical areas.</li> <li>• [Insert name] will be responsible for the maintenance of sterile equipment and supplies, and for ensuring all items remain "in date".</li> </ul> <p>At our inspection on 11 July 2017 records showed that the last infection control audit had been carried out by the practice on 17 August 2014. However, the audit failed to identify neither that the clinical wash-hand basin in the nurse's room was not compliant with Department of Health guidance or that there were no hand washing facilities available in the staff toilet on the first floor of the building. We saw that hand washing facilities were provided in the room adjacent to the staff toilet on the first floor of the building. However, hand drying facilities (paper towels) were only available in the kitchen on the first floor of the building.</p> <p>At our inspection on 20 March 2018 records showed that an infection control risk assessment had been conducted on 14 December 2017. However, the risk assessment still failed to identify that there were no hand washing facilities available in the staff toilet on the first floor of the building. We saw that hand washing facilities were still being provided in the room adjacent to the staff toilet on the first floor of the building.</p> <p>At our inspection on 9 October 2018 we asked for a copy of the practice's latest infection control audit. The practice provided us with a copy of their action plan to address issues identified by their infection control risk assessment dated 14 December 2017. We saw that hand washing facilities were now</p>	

available in the staff toilet on the first floor of the building. The practice also gave us a copy of an action plan that was produced by the local infection prevention team to address infection prevention and control issues at Dr Samuel Bhasme's practice. This document identified that some wash-hand basins in the practice were still not compliant with Department of Health guidance. It also identified that a sink that was being used by practice staff as a wash-hand basin was also being used to dispose of dirty water and body fluids. Although this document also contained notes indicating action to be taken to address identified issues, including dates by which the action should be taken, there were no records to demonstrate the action that the practice had taken or was planning to take. Staff told us that they were using the action plan that was produced by the local infection prevention team to address infection prevention and control issues at the practice. However, there were no practice records to confirm this.

At our inspection on 20 March 2018 we found that there were written cleaning schedules that indicated the frequency and method of domestic cleaning to be carried out in the practice. Staff told us that formal cleaning audits were not carried out but regular visual checks of the standard of cleaning conducted took place. However, there were no records to confirm this.

At our inspection on 9 October 2018 staff told us that formal cleaning audits were still not being carried out. However, they told us that regular visual checks of the standard of cleaning conducted took place and were recorded. Records confirmed this.

Mobile screens were used in consultation / treatment rooms to help maintain patients' privacy during examinations and treatments. However, there was no documentary evidence that the screens were cleaned on a regular basis.

Cleaning equipment was not always stored in line with current infection prevention and control guidance. For example, we saw that three mops were stored head down in buckets in a room on the first floor of the building.

Risks to patients	
The practice had systems to monitor and review staffing levels and skill mix.	Yes
There was an effective approach to managing staff absences and busy periods.	Yes
Staff knew how to respond to emergency situations.	Yes
All staff were up to date with basic life support training.	Yes
Emergency equipment and emergency medicines were available in the practice including medical oxygen and an automated external defibrillator (AED).	Yes
Records showed that emergency equipment and emergency medicines were checked regularly.	No
Emergency equipment and emergency medicines that we checked were within their expiry date.	Yes
There was up to date written guidance for staff to follow in the event of major incidents that contained emergency contact telephone numbers.	Yes
There was written guidance for staff to follow to help them identify and manage patients with severe infections. For example, sepsis.	Yes
Staff were up to date with training in how to identify and manage patients with severe infections. For example, sepsis.	No
The practice had systems to enable the assessment of patients with presumed sepsis in line with NICE guidance.	Yes
There was an up to date health and safety risk assessment that incorporated an action plan to address issues identified.	Yes
There was an up to date health and safety policy available with a poster in the practice which identified local health and safety representatives.	Yes
There was an up to date legionella risk assessment and an action plan to address issues identified. (Legionella is a germ found in the environment which can contaminate water systems in buildings).	No
Additional evidence or comments	
<p>At our inspection on 11 July 2017 we found that the practice did not have a child's oxygen mask available for use in an emergency.</p> <p>At our inspection on 20 March 2018 we found that that the practice still did not have a child's oxygen mask available for use in an emergency.</p> <p>At our inspection on 9 October 2018 we found that the practice now had a child's oxygen mask available for use in an emergency. However, the practice did not have an effective system for the checking of emergency equipment and emergency medicines when the lead member of staff (the practice nurse) was absent. Records showed that weekly checks were made of emergency equipment and emergency medicines. However, for a period of three weeks when the lead member of staff was on annual leave in August 2018 records showed that no such checks were made.</p> <p>We looked at the training records of five members of staff and found that none were up to date with recognition of patients with deteriorating conditions (such as sepsis) training.</p> <p>At our inspection on 9 October 2018 we asked for a copy of the practice's latest health and safety risk assessment. The practice gave us a document entitled 'risk assessments' that was dated 5 September 2018. The document identified risks to patients, staff and visitors and contained an action plan to</p>	

address issues identified. However, the practice was unable to demonstrate they had assessed the risks associated with building infrastructure that required maintenance. For example, a broken toilet seat in the staff toilet located on the ground floor. Staff told us that there were plans to repair the broken toilet seat. However, there were no records to confirm this. We asked if the practice had a premises maintenance programme. Staff told us that no maintenance was planned and that issues were dealt with on an ad hoc basis.

At our inspection on 11 July 2017 the practice was unable to demonstrate they had a system for the routine management of legionella.

At our inspection on 20 March 2018 the practice was unable to demonstrate they had an effective system for the routine management of legionella. There was a legionella management policy and records dated 12 September 2017 showed that the practice had carried out a test for the presence of legionella bacteria in their water system and the result was negative. However, staff told us that the practice had not carried out any other actions in order to reduce the risk of legionella. For example, a legionella risk assessment.

At our inspection on 9 October 2018 the practice was still unable to demonstrate they had an effective system for the routine management of legionella. The practice had still not carried out a legionella risk assessment. Records showed that regular monitoring of the temperature of water from hot and cold outlets was taking place. However, records also showed that between December 2017 and September 2018 the temperature of hot water in the practice nurse's room and the patient's toilet was regularly not reaching the required 50 degrees centigrade. The practice was unable to demonstrate they had any plans to address this issue. Staff told us that they did not regularly flush little used water outlets in the practice as there were none. However, we saw that there was a bathroom on the first floor of the building that was being used as a store room. The bathroom contained a sink and a bath that had clearly not been used for some time. The practice was unable to provide any documentary evidence to demonstrate that the water outlets in this bathroom had been flushed on a regular basis to reduce the risk of colonisation by legionella. Staff told us that the practice had recently carried out a test for the presence of legionella bacteria in their water system but the samples were not processed in a timely manner by the testing company. Staff told us they were about to send new samples for testing. We saw that the practice had a water testing kit to enable them to do so.



Information to deliver safe care and treatment	
Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation.	No
The care records we saw demonstrated that information needed to deliver safe care and treatment was made available to relevant staff in an accessible way.	No
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 used multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes
Additional evidence or comments	
<p>Staff told us that when other trained members of staff were used as a chaperone, this was not routinely recorded in the relevant patient's records.</p> <p>Records showed that the practice's computerised patient record system did not alert staff to children who were looked after. We looked at the electronic records of two children who were looked after, as well as the records of one adult who was a foster parent. The practice's computer records system did not alert staff to the fact that either of the children were looked after nor that the adult was responsible for any children that were looked after.</p>	

Medicine Management				
Indicator	Practice	CCG average	England average	England comparison
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)	14.0%	10.6%	8.7%	Variation (negative)
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). (01/07/2016 to 30/06/2017) (NHSBSA)	12.3%	10.7%	8.9%	Comparable to other practices
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)	2.19	0.99	0.83	Variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2016 to 30/06/2017) (NHSBSA)	2.57	1.10	0.90	Variation (negative)
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
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).				Yes
Blank prescription forms and pads were securely stored and there were systems to monitor their use.				No
Medicines that required refrigeration were appropriately stored, monitored and transported in line with Public Health England (PHE) guidance to ensure they remained safe and effective in use.				No
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
Up to date local prescribing guidelines were in use.				Yes
Additional evidence or comments				
Staff were unaware of the practice's performance results for the prescribing indicators in the above table. The practice did not have an action plan to improve their performance for the prescribing indicators in the above table.				
At our inspection on 11 July 2017 we found that there were processes for handling repeat prescriptions				

which included the review of patients who were prescribed high risk medicines. However, we saw that blood test results were not recorded in some patients' records when high risks medicines were prescribed. For example, we looked at six patients' records who were prescribed high risk medicines and saw that blood test results were only recorded in three of them.

At our inspection on 20 March 2018 we found that the practice had revised the processes for handling repeat prescriptions which included the review of patients who were prescribed high risk medicines. Written guidance had been introduced to help ensure staff followed best practice when prescribing high risk medicines. For example, the protocol for repeat prescriptions for methotrexate and warfarin (both high risk medicines). We looked at a random sample of patients' records who were prescribed high risk medicines and saw that blood test results had been recorded in all of them.

At our inspection on 9 October 2018 we found that blood test results were not recorded in some patients' records when high risk medicines were prescribed. For example, we looked at the records of 10 patients who were prescribed warfarin and saw that relevant blood test results were recorded before further prescriptions were issued. However, we looked at the records of all patients who were prescribed methotrexate and found that two did not show that blood test results were recorded before further prescriptions were issued.

At our inspection on 11 July 2017 we found that blank prescription pads were securely stored. However, blank prescription forms were not securely stored. Staff told us there were no systems to monitor the use of blank prescription pads and forms.

At our inspection on 20 March 2018 we found that blank prescription pads and forms were being securely stored. The practice had revised the system that monitored the use of blank prescription pads and forms. However, this did not record the serial numbers of blank prescription forms.

At our inspection on 9 October 2018 we found that the practice had introduced a system that logged the serial numbers of blank prescription forms. However, this was not effective at tracking their use throughout the practice. When staff took a batch of blank prescription forms from the main store they only recorded the serial number of the first form. They did not record the serial number of the last form from the batch taken. They were not, therefore, able to effectively track the whole batch of blank prescription forms through the practice.

At our inspection on 11 July 2017 we found that vaccines were not stored securely in line with PHE guidance. For example, vaccines were stored in a medicines refrigerator which was not kept locked. Appropriate temperature checks for refrigerators used to store medicines and vaccines had been carried out and records of those checks were made. However, these records showed that the maximum temperature of the vaccines refrigerator was outside of the recommended storage range of between two and eight degrees centigrade on 4 May 2017. There was written guidance available for staff on the monitoring of refrigerator temperatures. For example, the vaccine management and cold chain standards document. However, the practice was unable to demonstrate that staff had followed this written guidance on 4 May 2017 when the temperature of the vaccines refrigerator was recorded as being outside of recommended limits.

At our inspection on 20 March 2018 we found that vaccines were being stored at the practice in line with PHE guidance. Records showed that medicine stored in the practice's medicine refrigerators were being stored at the recommended temperature. The practice had an inventory system to monitor and help control stock levels of the vaccines they held.

At our inspection on 9 October 2018 we found that the improvements previously made had not been sustained. We found that not all vaccines were being stored at the practice in line with PHE guidance. For example, some vaccines were stored touching the inside walls of the medicine refrigerator.

Significant events	
There was a system for recording and acting on significant events.	Yes
Staff told us they would inform the GP of any incidents and there was a recording form available that supported the recording of notifiable incidents under the duty of candour.	Yes
Records showed that the practice had carried out a thorough analysis of all reported significant events.	Yes
There was evidence of learning and dissemination of information from all reported significant events.	Yes
Additional evidence or comments	
<p>At our inspection on 11 July 2017 we found that the practice did not have an effective system to manage significant events.</p> <p>At our inspection on 20 March 2018 we found that the practice had not made sufficient improvements to the system for reporting and recording significant events.</p> <p>At our inspection on 19 June 2018 we found that the practice had still not made sufficient improvements to the system for reporting and recording significant events. The practice was also unable to demonstrate there was a consistent approach to their management of significant events.</p> <p>At our inspection on 9 October 2018 records showed that the practice had retrospectively carried out analysis of all significant events reported by staff between November 2017 and July 2018. Records showed that these significant events had been discussed and any learning shared with relevant staff. Records also showed that relevant significant events had been reported to the National Reporting and Learning System (NRLS). For example, a near miss where a patient was prescribed the same medicine twice that had the potential to cause the patient harm.</p> <p>At our inspection on 9 October 2018 the practice was unable to provide us with a log of reported significant events. After our inspection the practice wrote to us and provided a log of their significant events. The log was dated October 2018 and indicated that it covered the preceding 12 months. However, significant events listed were not individually dated and it was not clear when in the last 12 months they had occurred. Staff told us that there had been no further significant events reported at the practice since 6 July 2018. However, staff had failed to report significant events that they had been alerted to through feedback about the practice left on the NHS Choices website. For example, feedback posted on the website between July 2018 and August 2018 indicated that a patient had experienced damage to their health as a result of not attending the practice as they did not have confidence in the GP. The feedback also indicated that a patient who contacted the out of hours service was advised by them to call their own GP and book an urgent appointment to be seen that day. This feedback indicated that the patient was not provided with an urgent appointment that day but was advised by the practice's reception staff to attend the local walk-in centre. Staff told us that they had replied to both sets of feedback via the NHS Choices but were not aware they had to report the feedback as significant events.</p>	

Safety Alerts	
The practice's systems for notifiable safety incidents ensured this information was shared with staff	Yes
Staff were aware of how to deal with notifiable safety incidents.	Yes
Additional evidence or comments	
<p>At our inspection on 11 July 2017 we found that the practice did not have effective systems that identified notifiable safety incidents.</p> <p>At our inspection on 20 March 2018 we found that the practice had systems for notifiable safety incidents. However, the practice did not always keep records of action taken (or if no action was necessary) in response to receipt of all notifiable safety incidents.</p> <p>At our inspection on 9 October 2018 we found that the practice was still not always keeping records of action taken (or if no action was necessary) in response to receipt of all notifiable safety incidents.</p>	

# Effective

Effective needs assessment, care and treatment					
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)	56.7%		75.9%	79.5%	Significant Variation (negative)
QOF Exceptions	Practice Exception rate (number of exceptions)		CCG Exception rate	England Exception rate	
	4.3% (7)		15.6%	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)	80.1%		75.8%	78.1%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)		CCG Exception rate	England Exception rate	
	1.8% (3)		11.5%	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)	61.8%		78.4%	80.1%	Variation (negative)
QOF Exceptions	Practice Exception rate (number of exceptions)		CCG Exception rate	England Exception rate	
	4.3% (7)		13.9%	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	69.5%		74.9%	76.4%	Comparable with other practices

(01/04/2016 to 31/03/2017) (QOF)					
QOF Exceptions	Practice Exception rate (number of exceptions)		CCG Exception rate	England Exception rate	
	0.8% (1)		12.8%	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)					Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)		CCG Exception rate	England Exception rate	
	0 (0)		16.2%	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)					Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)		CCG Exception rate	England Exception rate	
	0 (0)		5.1%	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)					Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)		CCG Exception rate	England Exception rate	
	6.5% (2)		5.4%	8.2%	
Additional evidence or comments					
The practice provided us with unverified data during our inspection that showed their current achievement in QOF data at 31 March 2018. This data showed that the practice had achieved 4.82 points out of total of 8 (60% achievement) for the diabetes mellitus related indicator DM008 by 31 March 2018. (The diabetes mellitus related indicator DM008 shows the percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 64mmol/mol or less in the preceding 12 months.) This demonstrated an increase of 3% over the results for the same indicator for the period					



2016/2017.

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)	25	28	89.3%	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)	22	30	73.3%	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)	22	30	73.3%	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)	22	30	73.3%	Below 80% (Significant variation negative)
Additional evidence or comments				
<p>The practice provided us with unverified data during our inspection that represented an estimation of what percentage coverage had been reached so far based on the information held in Open Exeter for the latest four quarters. The data was as follows;</p> <ul style="list-style-type: none"> <li>• Quarter 1 October 2018 Immunisations 0% Boosters 0%</li> <li>• Quarter 1 July 2018 Immunisations 87.5% Boosters 84.62%</li> <li>• Quarter 1 April 2018 Immunisations 86% Boosters 89.66%</li> <li>• Quarter 1 January 2018 Immunisations 83.93% Boosters 96.88%</li> </ul> <p>With the exception of boosters in the Quarter 1 January 2018, results were still below the target of 90%.</p>				



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)	69.8%	74.2%	72.1%	Comparable with other practices
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) <b>(PHE)</b>	63.1%	72.2%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %) <b>(PHE)</b>	48.0%	55.1%	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. <b>(PHE)</b>	100.0%	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)	25.0%	48.8%	51.6%	Comparable with other practices

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)	100.0%	89.7%	90.3%	Variation (positive)
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	5.6% (1)	17.1%	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%	91.2%	90.7%	Variation (positive)
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	0 (0)	13.4%	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)	100.0%	81.7%	83.7%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	0 (0)	8.6%	6.8%	

Monitoring care and treatment			
Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	523	532	539
Overall QOF exception reporting (all domains)	2.5%	6.5%	5.7%

Coordinating care and treatment	
Indicator	Y/N
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2016 to 31/03/2017) (QOF)	No
Additional evidence or comments	
<p>At our inspection on 11 July 2018 staff told us that the practice did not hold regular multidisciplinary team meetings. However, they said that telephone meetings with other services took place when required. For example, with district nurses and palliative care staff.</p> <p>At our inspection on 20 March 2018 staff told us that the practice did not hold regular multidisciplinary team meetings. However, they said that telephone meetings with other services were still taking place when required. For example, with district nurses and palliative care staff.</p> <p>At our inspection on 9 October 2018 staff told us that the practice was still not holding regular multidisciplinary team meetings. However, they said that telephone meetings with other services took place when required. For example, with local safeguarding authority staff and palliative care staff.</p>	

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)	96.5%	94.2%	95.3%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	0.2% (1)	1.1%	0.8%	

## Caring

Kindness, respect and compassion	
CQC comments cards	
Total comments cards received	0
Number of CQC comments received which were positive about the service	0
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
We spoke with seven patients who indicated they were satisfied with the care they received. They also stated that clinical staff were good at explaining tests and treatments as well as listening to them. Most of the patients we spoke with thought staff were approachable, helpful and caring. <b>However, two patients indicated that reception staff were rude and unhelpful.</b>	Patient interviews
<b>The practice was rated as two stars out of the attainable five relating to dignity and respect. There was mixed feedback about the practice left on the NHS Choices website. Some indicated that reception staff were rude.</b> Others indicated that patients were satisfied with the care they received from the GP.	NHS Choices feedback

National GP Patient Survey Results published in July 2017				
Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
2464	306	106	35%	4%
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)	89.7%	83.6%	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)	88.6%	82.6%	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%	93.5%	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)	82.9%	73.6%	83.8%	Comparable with other practices
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)	97.9%	90.8%	93.5%	Comparable with other practices
The percentage of respondents to the GP patient survey who stated they found the receptionists at this GP practice helpful (01/01/2018 to 31/03/2018)	68%	85%	90%	Variation (negative)
Additional evidence or comments				
Results from the national GP patient survey published at the time of our inspection on 11 July 2018 showed that 66% of respondents said they found the receptionists at the practice helpful (CCG average 83%, national average 87%).				
Results from the national GP patient survey published at the time of our inspection on 20 March 2018 showed that 66% of respondents said they found the receptionists at the practice helpful (CCG average 83%, national average 87%).				

Facilities to help patients be involved in decisions about their care	
Interpretation services were available for patients who did not have English as a first language.	Yes
A hearing loop was available for patients who had a hearing impairment.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Number and percentage of carers identified	Records showed that the practice had identified 20 patients on the practice list who were carers (1% of the practice list).
How the practice supports carers	The practice's computer system alerted GPs if a patient was also a carer. The practice had a system that formally identified patients who were also carers and written information was available to direct carers to the various avenues of support available to them. There was written guidance to help staff identify patients who were also carers. For example, the protocol for the identification and assessment of carers 2011 / 2012.

Privacy and dignity	
Screens were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Yes
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
Written guidance was available for staff to follow that helped to maintain patient confidentiality.	Yes

# Responsive

## Responding to and meeting people's needs

### Timely access to the service

#### Practice Opening Times

Day	Time
Monday	8am to 6.30pm
Tuesday	8am to 8pm
Wednesday	8am to 12.30am
Thursday	8am to 6.30pm
Friday	8am to 6.30pm

There were arrangements with other providers to deliver services to patients outside of the practice's working hours.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes

#### Additional evidence or comments

We looked at the records of four patients who had requested a home visit and found that they were not always triaged in a timely manner. For example, records showed that one patient requested a home visit for their relative, who was complaining of chest pain radiating through to their back, by telephoning the practice at 12.56am. The request was not triaged until 4.40pm.

National GP Patient Survey Results published in July 2017				
Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
2464	306	106	35%	4%
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)	93.5%	92.1%	94.8%	Comparable with other practices
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)	51.4%	57.4%	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)	45.3%	57.2%	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)	55.9%	55.1%	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)	57.1%	65.8%	74.4%	Comparable with other practices
Additional evidence or comments				
<p>Results from the national GP patient survey published at the time of our inspection on 11 July 2018 showed that 56% of respondents described their experience of making an appointment as good compared with the CCG average of 63% and the national average of 73%.</p> <p>Results from the national GP patient survey published at the time of our inspection on 20 March 2018 showed that 56% of respondents described their experience of making an appointment as good compared with the CCG average of 63% and the national average of 73%.</p>				



Examples of feedback received	Source
We spoke with seven patients most of whom indicated they could book a routine appointment or telephone consultation at a time that suited their needs. <b>Two patients told us they were not always able to book an appointment that suited their needs and another patient told us they were able to book an appointment that suited their needs if they telephoned the practice early in the day.</b>	Patient interviews.
The practice was rated as 1.5 stars out of the attainable five for the availability of appointments. Additionally, the practice scored 2.5 stars out of the attainable five for telephone access. Feedback about this practice left on the NHS Choices website indicated that a patient was unable to book an urgent appointment and was told by staff to go to the local walk in clinic instead. Other feedback left indicated that it was sometimes difficult to book an appointment that fitted in with a patient's work commitments.	NHS Choices feedback

Listening and learning from complaints received	
The practice had a system for handling complaints and concerns.	Yes
The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.	Yes
Information was available to help patients understand the complaints system.	Yes
Number of complaints received in the last 12 months.	11
<b>Records showed that complaints were satisfactorily handled in a timely manner.</b>	<b>Unclear</b>
<b>Records confirmed that complaints were discussed at staff meetings.</b>	<b>No</b>
<b>Learning as a result of complaints received was shared appropriately with practice staff.</b>	<b>Unclear</b>
Additional evidence or comments	
<p>At our inspection on 11 July 2017 we found that the practice's complaints policy contained reference to the role of the Primary Care Trust which was disbanded several years ago. The practice had received two written complaints during the period April 2016 to July 2017. Staff told us that verbal complaints received were not recorded and were dealt with by discussion only. This was not in line with the practice's own complaints policy. Records demonstrated that the written complaints were investigated and the complainants had received a response. The practice was unable to demonstrate that verbal complaints were investigated or that the verbal complainant had received a response. The practice was also unable to demonstrate they had learned from the complaints or had implemented appropriate changes.</p> <p>At our inspection on 20 March 2018 we found that the practice had revised their complaints policy which was in line with recognised guidance and contractual obligations for GPs in England. Records showed that the practice had not received any written complaints since our last inspection in July 2017. Verbal complaints were recorded in a book kept in the reception office. Records showed that the practice had received 13 verbal complaints since our last inspection in July 2017. The practice's complaints policy stipulated that complaints received should be discussed at practice meetings and recorded in the meeting minutes. Records showed that notes from staff meetings were made. However, these notes did not demonstrate that verbal complaints had been discussed or that learning from them had taken place.</p> <p>At our inspection on 9 October 2018 the practice gave us a copy of their complaints and feedback policy which was dated March 2018. The policy indicated that it related to Dr Samuel Bhasme's practice. <b>However, the policy indicated that all complaints, written and verbal should be recorded on the Radar system. The practice did not have a Radar system and staff we spoke with were not aware of what the Radar system was. The policy indicated that the regional manager, the local clinical director and the patient relationship manager should be informed if a request for investigating a complaint, where the</b></p>	

complainant remains unhappy with the practice's response, was received. The policy also indicated that staff should pass on details of verbal complaints to the deputy practice manager in the absence of the practice manager. The practice did not have a regional manager, a local clinical director, a patient relationship manager or a deputy practice manager.

Staff told us that the practice had not received any written complaints in the last 12 months. The practice was unable to provide us with a log of complaints received. After our inspection the practice wrote to us and provided a log of their complaints received. The log was dated October 2018 and indicated that it covered the preceding 12 months. However, complaints listed in the log were not individually dated so it was not clear when in the last 12 months they had occurred. Other records showed that there had been 11 verbal complaints received by the practice between 10 October 2017 and 22 December 2017.

Details of each verbal complaint had been recorded on individual verbal complaint / comment review forms. The forms contained a brief description of the event, learning points and specific action required. All 11 forms were completed fully and demonstrated learning points and action taken. For example, one form indicated that a patient had complained about a lack of afternoon appointments. Records showed that the patient was advised of the availability of appointment times and booked an evening appointment. Records also showed that the practice had learned that some patients would like afternoon appointments and indicated that the practice would look into if this would be possible. However, the form did not record when the patient had been contacted after they had made the complaint. There were no records to demonstrate that any of the 11 verbal complaints had been discussed at staff meetings or how learning from them had been shared with staff.

We saw that there had been three sets of feedback about the practice left on the NHS Choices website since April 2018. All three contained negative comments. For example, one indicated that patients found it difficult to book an appointment that fitted into their work commitments. This set of feedback also contained positive comments about the practice. The practice had responded to the comment via the NHS Choices website. However, the practice failed to respond to the negative aspect of the feedback.

## Well-led

Leadership, capacity and capability	
Culture	
Records showed that the practice held regular staff meetings.	Yes
Minutes of staff meetings were available to those who were not able to attend the meetings.	Yes
The provider had systems to ensure compliance with the requirements of the Duty of Candour.	Yes
The practice gave affected people reasonable support, truthful information and a verbal or written apology when things went wrong with care and treatment.	Yes
Governance arrangements	
The practice had systems that helped to keep governance documents up to date.	Yes
Governance documents that we looked at were up to date and contained a review date.	Yes
Additional evidence or comments	
Some policy documents were incomplete or inaccurate. For example, the infection control policy as well as the complaints and feedback policy.	
Managing risks, issues and performance	
Records showed that clinical audits had been carried out.	Yes
Records showed that the practice had analysed clinical audit results and implemented action plans to address findings.	Yes
Records showed that clinical audits had been repeated to complete the cycle of clinical audit.	Yes
The practice had written guidance for staff to follow in the event of major incidents.	Yes
Written major incident guidance contained emergency contact telephone numbers for staff.	Yes
Engagement with patient, the public, staff and external partners	
The practice had an active patient participation group.	No
The practice gathered feedback from patients through the patient participation group.	No
The practice gathered feedback from patients by carrying out surveys.	Yes
The practice gathered feedback from patients through analysis of the results of the national GP patient survey.	Yes
The practice gathered feedback from staff through staff meetings, surveys, appraisals and discussion.	Yes

## 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](#)).