

# Care Quality Commission

## Inspection Evidence Table

### West Street Surgery (1-540962306)

Inspection date: 18<sup>th</sup> September 2018

Date of data download: 05 September 2018

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

## Safe

### Safety systems and processes

Safeguarding	Y/N
There was a lead member of staff for safeguarding processes and procedures.	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)	N**
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:  *Safeguarding policies and reports were not formally shared with staff due to a lack of practice meetings.  **The training record provided following the inspection showed that not all staff had completed safeguarding training.  ***Some staff reported the safeguarding register was out of date due to limited contact with the health visiting team. This register had not been circulated to staff since June 2018, when a member of the administration team left the practice. Shortly after the inspection, the practice confirmed that the safeguarding register was correct at the time of inspection.	

Recruitment Systems	Y/N
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N*
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	N**
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>*Not all staff had appropriate DBS checks or risk assessments completed prior to starting employment at the practice.</p> <p>**The Hepatitis B status was held for clinical staff. Shortly after the inspection, a policy was provided stating that all non-clinical staff who worked regularly with specimens would be offered a Hepatitis B vaccination. However, the practice was unable to provide evidence to confirm this had this had been done. A record of staff flu vaccinations was available shortly after the inspection. No other immunisation records were held.</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 06/09/18
There was a record of equipment calibration Date of last calibration:	Y 06/09/18
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals	Y
Fire procedure in place	N
Fire extinguisher checks	Y
Fire drills and logs	N
Fire alarm checks	Y
Fire training for staff	N
Fire marshals	Y
Fire risk assessment Date of completion	N
Actions were identified and completed.	N
Additional observations:	N
<b>Health and safety</b> Premises/security risk assessment? Date of last assessment:	N
Health and safety risk assessment and actions Date of last assessment:	N
<p>Additional comments:</p> <p>Staff reported there had been one fire drill carried out in the previous two years. We saw evidence of a fire drill being completed in September 2018. The practice did not provide evidence that fire drills were being conducted on a regular basis. Following the inspection, the provider told us that previous fire drill records been misplaced and therefore were not available for us to view during our inspection.</p> <p>Not all staff had completed fire safety training.</p> <p>The building was visibly clean and tidy with no obvious health and safety risks.</p> <p>A legionella risk assessment had been carried out in August 2018. However, actions had not been</p>	

completed. For example, the cold-water storage tank lid had collapsed into the tank and this had not been rectified.

Infection control	Y/N
<p>Risk assessment and policy in place</p> <p>Date of last infection control audit:</p> <p>The practice acted on any issues identified</p> <p>Detail:</p> <p>Action to change pillows to an impermeable material – completed</p> <p>Action to change bins to pedal bins with a lid – completed</p> <p>Action to book an outside contractor to fit alcohol rub dispensers – completed</p>	<p>Y*</p> <p>May 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:</p> <p>The infection control policy held by the nursing team was not practice specific and was produced by the CCG. It was dated 2016.</p> <p>There was a second infection control policy which was practice specific and was reviewed in March 2018, however this policy was not being followed by the practice.</p>	

Any additional evidence

## 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
<p>Explanation of any answers:</p> <p>*Staff reported that locum GP absences were not managed appropriately by practice management. Staff reported that GP partners would often arrive up to one hour late for sessions.</p> <p>**There was no formal training in place for receptionists regarding acutely unwell patients or patients showing 'red flag' symptoms of sepsis. However, staff we spoke with had an awareness of how to manage acutely unwell patients and gave examples of this being done. Clinical staff were able to manage acutely unwell patients.</p> <p>Spill kits were available for the spillage of bodily fluids however if there was a spillage of urine in the patient toilets the reception staff informed us they were responsible for cleaning these spillages. Staff we spoke with were unaware of which mop to use and therefore this was not used appropriately.</p>	

## 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*
<p>Explanation of any answers:</p> <p>*Referrals and letters that were received by post were scanned onto the care record system and read codes were recorded prior to being sent to a GP for review. Although a member of the senior team</p>	

triaged urgent letters, staff told us there was a delay of up to two weeks before these letters were seen by a clinician in some cases. We saw no evidence of harm to patients due to this system and there was no back-log of referrals seen.

## Appropriate and safe use of medicines

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2017 to 30/06/2018) NHS Business Service Authority - NHSBSA)	0.86	1.00	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)	7.5%	8.2%	8.7%	Comparable with other practices

Medicines Management	Y/N
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	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.	N
The practice monitored the prescribing of controlled drugs. (For example, audits for unusual prescribing, quantities, dose, formulations and strength).	N
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	N
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.	Y
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.	N/A
The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.	N
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*
<p>Explanation of any answers:</p> <p>High risk medicines - blood test results for patients prescribed high risk medicines were not recorded in the patient computer record prior to the medicine being prescribed. There were 53 patients on methotrexate of which 33 did not have blood results recorded on the system prior to the medicine being prescribed. We checked the patient computer records for four of these and found that the results were on the hospital recording system. However, these results had not been transferred to the patient computer record. There were four patients who were prescribed Lithium of which two did not have blood results recorded on the patient computer record however, both of these were checked and on the hospital system. There were 124 patients were prescribed warfarin with no blood results on the computer record. We checked five of these patients and two results were on the hospital system. There were no results available for the other three patients. GP's reported that although they prescribed the warfarin, the dosage was managed by the anticoagulant team.</p> <p>There was no evidence of audits being carried out on the prescribing of controlled drugs.</p> <p>There was no evidence of formal risk assessments regarding what emergency medicines were held in the practice, however, all recommended emergency medicines were held. All emergency medicines were stored in a locked cupboard within a locked treatment room to which all appropriate staff had access.</p> <p>*There were some gaps in the records of fridge temperature checks to support the appropriate use of the cold chain. Records showed that most weeks included at least one day where temperatures had not been checked. A significant event regarding the fridge being left open had been appropriately managed, investigated and recorded.</p>	

## 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	N
Number of events recorded in last 12 months.	24
Number of events that required action	24

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

Event	Specific action taken
Incomplete ENT referral	The practice manager discussed with GP who was unsure why the referral had not been made The GP is now going to keep a log of all referrals made and follow-up a week later to ensure they have been completed.
New baby not registered, immunisations not received.	All new baby registrations are to be added at the time of receipt of the Mother and baby Discharge Letter from the hospital. Once the Discharge Letter has been scanned onto the patient computer record system it is forwarded to the reception team lead who will add the baby using the details and NHS number on the discharge sheet. The details can be amended once the full paperwork is brought into the surgery.
Smoking Cessation Medication - acute prescription issued by a receptionist with the incorrect dose.	Only GP's or the Nurse prescriber can issue acute medicine. Discussions were held with the reception team lead who will feed back to the receptionists that only repeat medicines can be issued by reception staff. The protocol that was used is to be checked to identify where the error occurred and is to be reviewed.

Safety Alerts	Y/N
There was a system for recording and acting on safety alerts	N*
Staff understand how to deal with alerts	Y
<p>Comments on systems in place:</p> <p>*Safety alerts were sent via e-mail to the relevant staff members however, there was no managerial oversight of actions being taken. There was no evidence that safety alerts were recorded. We looked at a recent safety alert regarding the use of medications in pregnant women and this had been appropriately managed.</p>	



# Effective

## Effective needs assessment, care and treatment

Prescribing				
Indicator	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2017 to 30/06/2018) (NHSBSA)	1.30	0.90	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)	85.5%	78.8%	79.5%	Comparable with other practices
<b>QOF Exceptions</b>	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	14.3% (92)	12.9%	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)	87.8%	76.1%	78.1%	Comparable with other practices
<b>QOF Exceptions</b>	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	27.1% (174)	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)	89.9%	81.3%	80.1%	Variation (positive)
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	24.8% (159)	14.8%	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)	75.8%	77.1%	76.4%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	3.1% (24)	8.3%	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)	94.0%	89.6%	90.4%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	18.3% (41)	13.7%	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)	87.0%	83.5%	83.4%	Comparable with other practices
<b>QOF Exceptions</b>	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	4.6% (89)	4.7%	4.0%	
Indicator	Practice	CCG average	England average	England comparison
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2016 to 31/03/2017) (QOF)	86.6%	89.5%	88.4%	Comparable with other practices
<b>QOF Exceptions</b>	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	7.6% (16)	7.2%	8.2%	
<b>Any additional evidence or comments</b>				
<p>Exception reporting rates were above national and local averages in some areas, particularly around long-term conditions. This was reviewed by the inspection team and we found some staff had not correctly followed the exception reporting policy. We discussed this with the practice during the inspection and they were unable to fully explain this. However, they did identify that they needed to review the policy and they assured us that this would be completed following the inspection. We received evidence that showed us this had been done. The practice understood that this would need to be embedded into practice.</p>				

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)	151	157	96.2%	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)	131	147	89.1%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2016 to 31/03/2017) (NHS England)	131	147	89.1%	Below 90% minimum (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)	130	147	88.4%	Below 90% minimum (variation negative)
<b>Any additional evidence or comments</b>				

Working age people (including those recently retired and students)

<b>Cancer Indicators</b>				
<b>Indicator</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
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)	79.1%	74.3%	72.1%	Comparable with other practices
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE)	79.4%	70.8%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE)	59.5%	55.5%	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)	56.1%	61.6%	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)	62.7%	54.9%	51.6%	Comparable with other practices
<b>Any additional evidence or comments</b>				
The practice was unable to provide evidence of healthchecks being completed. There was no system in place to identify patients who were eligible for health checks or who had attended.				



People experiencing poor mental health (including people with dementia)

<b>Mental Health Indicators</b>				
<b>Indicator</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
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)	90.0%	89.6%	90.3%	Comparable with other practices
<b>QOF Exceptions</b>	<b>Practice Exception rate (number of exceptions)</b>	<b>CCG Exception rate</b>	<b>England Exception rate</b>	
	52.4% (22)	15.5%	12.5%	
<b>Indicator</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
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)	95.8%	90.5%	90.7%	Comparable with other practices
<b>QOF Exceptions</b>	<b>Practice Exception rate (number of exceptions)</b>	<b>CCG Exception rate</b>	<b>England Exception rate</b>	
	42.9% (18)	13.6%	10.3%	
<b>Indicator</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
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)	78.8%	85.1%	83.7%	Comparable with other practices
<b>QOF Exceptions</b>	<b>Practice Exception rate (number of exceptions)</b>	<b>CCG Exception rate</b>	<b>England Exception rate</b>	
	8.0% (7)	6.7%	6.8%	
<b>Any additional evidence or comments</b>				
Exception reporting rates were above national and local averages in some areas, particularly around long-term conditions. This was reviewed by the inspection team and we found some staff were not correctly following the exception reporting policy. We discussed this with the practice during the inspection they were unable to fully explain this. However, they did identify that they needed to review the policy and they assured us that this would be completed following the inspection. We received evidence that this had been done. The practice understood that this would need to be embedded into practice.				

## Monitoring care and treatment

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	553	536	539
Overall QOF exception reporting (all domains)	7.3%	5.9%	5.7%

### Any additional evidence

We saw evidence of clinical audits that were completed by the GP partners. Audits had led to a change of treatment for patients at that time however, we saw no evidence to show that the practice had implemented systemic changes in patient management to prevent recurrence. For example, we saw an audit completed for patients that had been prescribed two anticoagulant medicines for a period of over one year. At the time of the audit, the medicine was changed to reflect current guidance however, there was no changes made to the system of anticoagulation review. At the time of re-audit, a similar number of patients required their medicines to be adjusted again.

## 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)	Y

## 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)	98.8%	94.9%	95.3%	Variation (positive)
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	1.9% (58)	0.8%	0.8%	

## Consent to care and treatment

Description of how the practice monitors that consent is sought appropriately
We looked at examples of consent. Staff had created consent forms for certain clinics that they audited themselves. We saw examples of where consent was gained appropriately from both the nursing and GP team. The vasectomy clinic sought consent appropriately.

Any additional evidence
<p>The practice advised that health checks were offered appropriately however the practice was unable to provide information regarding the number of health checks that had been completed. We spoke with seven patients on the day and none of these had been invited for a health check. The number of care plans completed were as follows:</p> <p>Learning disability – 52 on register, 0 with care plans</p> <p>Dementia – 76 on register, 3 with care plans</p> <p>Mental health – 105 on register, 0 with care plans</p> <p>Depression – 1038 on register, 0 with care plans</p> <p>Palliative care – 42 on register, 2 with care plans</p> <p>Cancer patients – 401 on register, 16 with care plans</p>

# Caring

## Kindness, respect and compassion

CQC comments cards	
Total comments cards received	13
Number of CQC comments received which were positive about the service	11
Number of comments cards received which were mixed about the service	2
Number of CQC comments received which were negative about the service	0

Examples of feedback received:

Source	Feedback
Interviews with patients.	Patients felt that they were treated with kindness and compassion. Patients felt their privacy and dignity was respected.
CQC comments cards	Comment cards refer to helpful reception staff and a supportive nursing team.
PPG feedback	Feedback from the Patient Participation Group (PPG) was good and they have been involved in improvements within the practice. The PPG felt that meetings would be more beneficial if the GP partners attended
Local nursing and residential homes	Local care homes felt supported by the practice and commented that the relationship was good. One nursing home described a situation where a patient needed medicine urgently and the practice was extremely helpful in ensuring this was completed.

## 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
12323	262	109	41.6%	0.88%

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)	87.2%	88.7%	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)	80.1%	85.7%	87.4%	Comparable with other practices
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	95.8%	95.7%	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)	76.5%	82.0%	83.8%	Comparable with other practices
<b>Any additional evidence or comments</b>				

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

Date of exercise	Summary of results

Any additional evidence
The PPG reported that a patient survey had been suggested but this was not taken up by the GP partners

## Involvement in decisions about care and treatment

Examples of feedback received:

Source	Feedback
Interviews with patients.	We spoke with seven patients on the day and they all reported that they had enough time with the GP and felt involved in their care and treatment.

## National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	90.2%	92.7%	93.5%	Comparable with other practices

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	12
How the practice supports carers	Practice management reported that a carers stand was placed in the reception area once a month. There was no evidence of a carers lead or supporting materials being available in the reception area for patients.
How the practice supports recently bereaved patients	The practice sent a letter to bereaved patients. The Nursing team attended funerals of patients known to them. The community matron conducted bereavement visits for support.



## 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	<p>The reception desk was away from the main waiting area.</p> <p>Telephone calls were not answered on the front desk. An enclosed reception office was used for all phone calls</p> <p>We saw receptionists on the front desk speaking in a low voice to avoid being overheard.</p>

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
Interviews with patients	Patients we spoke with told us that they felt their privacy and dignity was maintained throughout their care and treatment.

# Responsive

## Responding to and meeting people's needs

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

Appointments available	
Pre-bookable, on-the-day and telephone	
Extended hours opening	
The practice had set up a community interest business in conjunction with five other local practices to provide extended access to patients. This commenced in September 2018.	

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	
The practice employed a practice based community matron who completed regular home visits. The GP also completed home visits were necessary.	

## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
12323	262	109	41.6%	0.88%

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)	97.0%	94.1%	94.8%	Comparable with other practices

## 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)	55.3%	69.0%	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)	56.3%	66.2%	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)	58.5%	61.4%	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)	63.2%	71.7%	74.4%	Comparable with other practices
<p><b>Any additional evidence or comments</b></p> <p>The practice was aware of the lower than average GP patient survey results that were related to patient access. There were no plans in place to change systems or practice because of this. We saw that seven reception staff members were able to take phone calls at any one time and the practice felt this was sufficient.</p> <p>The practice system of managing referrals and correspondence meant there could be a two week delay in GP's reviewing these letters. This could lead to a delay in patients receiving initial assessment, test results, diagnosis or treatment.</p>				

### Examples of feedback received from patients:

Source	Feedback
For example, NHS Choices	The patients we spoke with on the day were largely satisfied with the appointment availability however, two patients referred to long waits when trying to phone the practice and that there was limited appointment availability.

## Listening and learning from complaints received

Complaints	Y/N
Number of complaints received in the last year.	25
Number of complaints we examined	3
Number of complaints we examined that were satisfactorily handled in a timely way	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman	0
Additional comments:	
<p>One complaint that we reviewed included an action plan to provide training to the relevant staff members however, there was no evidence that this had been completed.</p> <p>One complaint had been discussed in the practice business meetings attended by the partners and team leaders however, the practice could not provide evidence of other complaints received being discussed.</p> <p>A complaints policy was available to staff. Patient complaints leaflets were held at reception and there was information available in the waiting area.</p>	

Example of how quality has improved in response to complaints
<p>The practice did not provide evidence of analysis of trends from complaints. Complaints were dealt with on an individual basis by the practice management.</p>

Any additional evidence
<p>An analysis trend of complaints was completed by the inspection team and we found there was a trend relating to clinical treatment and medication errors.</p>

# Well-led

## Leadership capacity and capability

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

There was poor governance within the practice which lacked overall leadership from the provider.

### Any additional evidence

## Vision and strategy

### Practice Vision and values

The practice had a vision to provide high quality, safe care to patients with an adaptable approach to changing needs and a respect for patient suggestions and expectations. The staff were unaware of the practice values and worked in line with their own personal values.

## Culture

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

There was a disjointed way of working where individual teams (such as nursing and reception teams), supported each other, managed their own performance and looked for ways to improve patient care.

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

Source	Feedback
Staff	Staff told us they felt unsupported by practice management and there was poor communication. Staff reported they felt unsupported and undervalued. Staff reported teams were not treated equally. Staff reported incidents where members of the management team did not appear to work in a patient-centred way. Staff reported that they felt their concerns were not listened to. The individual teams supported each other and provided the care they felt was right but there was little insight and direction from the provider.

### Any additional evidence

There were no whole practice meetings taking place and this affected communication. There were no forums to discuss significant events, incidents, safeguarding or practice changes. Nurses met on a weekly basis but they told us that GP partners rarely attend these meetings. The reception team met with the practice manager on a quarterly basis. Multi-disciplinary team clinical meetings were held on a four-weekly basis but poorly attended by community teams due to invites not being sent. Following our inspection, the provider informed us that regular nurses, management and GP partners meetings were held and weekly lunchtime forums had been implemented.

## Governance arrangements

Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care.	
Practice specific policies	The practice had a number of policies and procedures that were electronically available to all staff.
	<b>Y/N</b>
Staff were able to describe the governance arrangements	Y
Staff were clear on their roles and responsibilities	Y

Any additional evidence
There was no lone working policy or risk assessment to mitigate the risks associated with this.

## Managing risks, issues and performance

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

## Examples of actions taken to address risks identified within the practice

Risk	Example of risk management activities
Poor communication with community teams due to poor attendance at MDT meetings	The practice intended to ensure that external invites were being sent however, there was no evidence of this happening at the time of our inspection. The practice intended to review the content of this meeting to include palliative patients that did not have a cancer diagnosis.

Any additional evidence

## Appropriate and accurate information

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

Any additional evidence

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

### Feedback from Patient Participation Group;

Feedback
Feedback from the PPG was positive and they felt they had made an impact on the practice. The PPG had been involved in the decision making regarding the restructure of the reception and waiting room areas.

Any additional evidence
The practice had a patient suggestion box in reception however, there was no evidence to how this was used to improve practice.

## Continuous improvement and innovation

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

Audit area	Improvement
Clinical audits around usage of certain drugs, for example anti-coagulants	Patient's care and treatment was altered at the time of the audit. However, there were no systematic changes made to highlight these patients in the future. These were two cycle audits where the same changes needed to be made at the re-audit.

Any additional evidence
We found that there was no analysis of trends within significant events and there was no evidence of these being shared with staff. We found three incidents, for example a patient had collapsed in the reception that was not recorded as a significant event.

### 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](#)).