

# Care Quality Commission

## Inspection Evidence Table

### NEATH HILL HEALTH CENTRE (K82060)

Inspection date: **6 November 2018**

Date of data download: 14 November 2018

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Please Note: CQC was not able to automatically match data for this location to our own internal records. Data for the ODS code noted above has been used to populate this Evidence Table. Sources are noted for each data item.

## Safe

### Safety systems and processes

| Safeguarding  | Y/N |
|---|-----|
| There was a lead member of staff for safeguarding processes and procedures.   | Yes |
| Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff.   | Yes |
| Policies were in place covering adult and child safeguarding.   | Yes |
| Policies were updated and reviewed and accessible to all staff.   | Yes |
| Doctors and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs)  | No  |
| Information about patients at risk was shared with other agencies in a timely way.  | Yes |
| Systems were in place to highlight vulnerable patients on record. There was a risk register of specific patients  | Yes |
| Disclosure and Barring Service checks were undertaken where required  | Yes |
| Explanation of any 'No' answers:<br><br>Evidence of up to date training for all non-clinical staff was not available. The practice utilised an online training programme to support staff training. |     |

| Recruitment Systems   | Y/N |
|---|-----|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).         | Yes |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role. | No  |

|  |     |
|--|-----|
| Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.   | Yes |
| Staff who require medical indemnity insurance had it in place  | Yes |
| <p>Explanation of any answers:</p> <ul style="list-style-type: none"> <li>• Evidence of non-clinical staff immunity status was lacking. The practice had not undertaken a risk assessment of the lack of assurance taken from non-clinical staff in relation to their immunity status.</li> <li>• The practice did not have an established system for checking all staff were registered appropriately. We did not find any evidence of staff who were not appropriately registered with a clinical body in line with requirements.</li> </ul> |     |

| Safety Records  | Y/N                      |
|---|--------------------------|
| There was a record of portable appliance testing or visual inspection by a competent person<br>Date of last inspection/Test:  | Yes<br>August<br>2018    |
| There was a record of equipment calibration<br>Date of last calibration:  | Yes<br>September<br>2018 |
| Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals   | Yes                      |
| Fire procedure in place   | Yes                      |
| Fire extinguisher checks  | Yes                      |
| Fire drills and logs  | Yes                      |
| Fire alarm checks   | Yes                      |
| Fire training for staff   | No*                      |
| Fire marshals   | Yes                      |
| Fire risk assessment<br>Date of completion  | Yes<br>September<br>2016 |
| Actions were identified and completed.<br>There was no evidence to suggest that identified actions had been completed. For example, there was an action noted for NHS property services to repair a fire door that was not closing properly. Records available did not identify whether this had been done. |                          |
| Additional observations:<br>* Records of fire training for all staff were not available on the day of inspection.   |                          |
| <b>Health and safety</b><br>Premises/security risk assessment?<br>Date of last assessment:  | No<br>n/a                |
| Health and safety risk assessment and actions<br>Date of last assessment:   | No<br>n/a                |
| Additional comments:<br>The practice had not undertaken a health and safety or premises risk assessment.  |                          |

| 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>We saw evidence of three infection control audits undertaken by the CCG since August 2017. Over this time the practice had improved its compliance score from 65% to 84%. We saw a new splashback area in the treatment room had been installed following an audit.</p> <p>Detail:</p> <p>Several areas of improvement were noted on the most recent audit including the need for formal sepsis training for staff. It was also noted that the practice was to develop a cold chain policy and to ensure it was available for staff. We reviewed records of fridge maintenance and logs of temperature checks and found there were no identified concerns.</p> | <p>Yes</p> <p>27/09/18</p> |
| <p>The arrangements for managing waste and clinical specimens kept people safe?</p>  | <p>Yes</p>                 |
| <p>Explanation of any answers:</p> <p>The most recent infection control audit undertaken by the CCG stated that the practice should undertake a risk assessment to provide assurance with regard to non-clinical staff immunity status, this had not been done.</p> <p>We saw there were several areas within the practice that were in need of decorative repair. The practice advised that the building had experienced some subsidence which had resulted in cracks to the walls. The practice was in ongoing discussions with the landlords to rectify these concerns and improve the practice's compliance with infection prevention and control standards.</p>   |                            |

| Any additional evidence   |
|---|
| <p>On the day of inspection there was no evidence of a Legionella risk assessment. The practice provided evidence of a contract held for water sample testing to be undertaken twice a year. Following our inspection, we were sent a Legionella risk assessment undertaken in September 2017. We noted that there were areas identified as being high risk within the risk assessment and that a recommended schedule of water temperature checking and flushing of outlets was provided. We were not provided with any evidence to suggest that these checks were being undertaken.</p> |

## Risks to patients

| Question   | Y/N     |
|--|---------|
| There was an effective approach to managing staff absences and busy periods.   | No      |
| Comprehensive risk assessments were carried out for patients.  | No      |
| Risk management plans were developed in line with national guidance.   | No      |
| Staff knew how to respond to emergency situations.   | Yes     |
| Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.  | Partial |
| In addition, there was a process in the practice for urgent clinician review of such patients.   | Yes     |
| The practice had equipment available to enable assessment of patients with presumed sepsis.  | Yes     |
| There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.  | Yes     |
| Explanation of any answers: <ul style="list-style-type: none"> <li>• Staff advised that there was insufficient support for the practice manager which resulted in excessive workloads.</li> <li>• The practice did not have a comprehensive approach to risk management.</li> <li>• Clinical staff were aware of the signs and symptoms of sepsis and were well equipped to deal with patients with presumed sepsis. However, non-clinical staff we spoke with were not clear on the signs of sepsis or the appropriate action to be taken.</li> </ul> |         |

## Information to deliver safe care and treatment

| Question   | Y/N |
|--|-----|
| Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation.   | 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 use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.  | Yes |
| Explanation of any answers: <p>We found there were significant numbers of historic new patient paper records in need of summarising. The practice advised that due to insufficient staffing levels there was a backlog of two years of records awaiting summarising.</p> |     |

## Appropriate and safe use of medicines

| Indicator  | Practice | CCG average | England average | England comparison      |
|--|----------|-------------|-----------------|-------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2017 to 30/06/2018) NHS Business Service Authority - NHSBSA)                                | 0.91     | 1.00        | 0.95            | No comparison available |
| 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) | 7.7%     | 7.2%        | 8.7%            | No comparison available |

| Medicines Management  | Y/N |
|---|-----|
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.   | Yes |
| Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).  | Yes |
| Prescriptions (pads and computer prescription paper) were kept securely and monitored.  | No  |
| 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 |
| The practice monitored the prescribing of controlled drugs. (For example audits for unusual prescribing, quantities, dose, formulations and strength).  | Yes |
| There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.   | Yes |
| If the practice had controlled drugs on the premises there were systems for the safe ordering, checks on receipt, storage, administration, balance checks and disposal of these medicines in line with national guidance. | n/a |
| Up to date local prescribing guidelines were in use.  | Yes |
| Clinical staff were able to access a local microbiologist for advice.   | Yes |
| For remote or online prescribing there were effective protocols in place for identifying and verifying the patient in line with General Medical Council guidance.   | n/a |
| The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.  | Yes |
| The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.  | Yes |
| There was medical oxygen on site.   | Yes |
| The practice had a defibrillator.   | Yes |

|   |     |
|---|-----|
| Both were checked regularly and this was recorded.  | Yes |
| Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.   | Yes |
| <p>Explanation of any answers:</p> <ul style="list-style-type: none"> <li>• Systems for managing the security of blank prescription forms needed strengthening. We saw that prescriptions were not tracked through the practice to monitor their use and reduce risk. Immediately following our inspection, we were sent evidence that the practice had amended their protocol for prescription handling to reduce identified risks.</li> </ul> |     |

## Track record on safety and lessons learned and improvements made

| Significant events  | Y/N  |
|---|------|
| There was a system for recording and acting on significant events   | Yes  |
| Staff understood how to report incidents both internally and externally   | Yes  |
| There was evidence of learning and dissemination of information   | No   |
| Number of events recorded in last 12 months.  | Five |
| Number of events that required action   | Five |
| Any additional evidence   |      |
| <ul style="list-style-type: none"> <li>The practice was able to demonstrate evidence of learning and shared lessons in some areas but not all. For example, we saw a significant event had been recorded following a case of sepsis. We saw the practice had reviewed the incident and was satisfied with the action taken. However, this incident had not been shared with all staff. Non-clinical staff we spoke with were not aware of the signs and symptoms of sepsis or the required action to be taken. An infection control audit undertaken by the CCG in September 2018 also identified the need for staff to receive training on sepsis.</li> <li>The practice did not undertake a routine analysis of significant events or complaints to identify trends and take action to improve safety in the practice.</li> </ul> |      |

Example of significant events recorded and actions by the practice;

| Event                                   | Specific action taken  |
|---|--|
| Patient presented with signs of sepsis. | The practice recorded the incident as a significant event and reviewed the action taken. Although the practice was satisfied that appropriate action had been taken to support the patient, signs on sepsis were displayed in all clinical rooms to provide further assurance. |

| Safety Alerts   | Y/N |
|---|-----|
| There was a system for recording and acting on safety alerts  | Yes |
| Staff understand how to deal with alerts  | Yes |
| Comments on systems in place:<br>The practice pharmacist and practice nurse acted in response to safety alerts. However, a log of safety alerts received and actions taken was not maintained. There was no evidence that safety alerts were routinely discussed within the practice. |     |



## Effective

Please note the Quality and Outcomes Framework data used incorporates data relating to the previously registered provider for Neath Hill Health Centre for the period 1 April 2017 to 31 March 2018.

### Effective needs assessment, care and treatment

| Prescribing  |                      |             |                 |                         |
|--|----------------------|-------------|-----------------|-------------------------|
| Indicator  | Practice performance | CCG average | England average | England comparison      |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2017 to 30/06/2018) (NHSBSA) | 0.67                 | 0.85        | 0.83            | No comparison available |

### 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 (01/04/2017 to 31/03/2018) (QOF)                        | 71.7%  | 77.9%              | 78.8%                  | No comparison available |
| QOF Exceptions   | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                         |
|  | 6.2% (13)                                      | 14.0%              | 13.2%                  |                         |
| 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 (01/04/2017 to 31/03/2018) (QOF) | 82.6%  | 76.9%              | 77.7%                  | No comparison available |
| QOF Exceptions   | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                         |
|  | 4.7% (10)                                      | 11.2%              | 9.8%                   |                         |

| 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 (01/04/2017 to 31/03/2018) (QOF) | 82.4%  | 83.0%              | 80.1%                  | No comparison available |
| QOF Exceptions  | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                         |
|   | 8.5% (18)                                      | 13.7%              | 13.5%                  |                         |

| 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 (01/04/2017 to 31/03/2018) (QOF)          | 79.2%  | 77.3%              | 76.0%                  | No comparison available |
| QOF Exceptions   | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                         |
|  | 20.9% (33)                                     | 11.0%              | 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 (01/04/2017 to 31/03/2018) (QOF) | 68.6%  | 90.5%              | 89.7%                  | No comparison available |
| QOF Exceptions   | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                         |
|  | 7.9% (3)                                       | 14.3%              | 11.5%                  |                         |

| 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 (01/04/2017 to 31/03/2018) (QOF)   | 80.3%  | 80.0%              | 82.6%                  | No comparison available |
| QOF Exceptions  | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                         |
|   | 3.3% (13)                                      | 5.5%               | 4.2%                   |                         |
| 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 (01/04/2017 to 31/03/2018) (QOF) | 92.1%  | 90.5%              | 90.0%                  | No comparison available |
| QOF Exceptions  | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                         |
|   | 0 (0)  | 5.0%               | 6.7%                   |                         |

#### Any additional evidence or comments

We reviewed data for the Quality and Outcomes Framework 2017/2018 and found that performance for these indicators was largely in line with local and national averages. However, performance for 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 was below local and national averages and dropped from the previous year's performance of 96 % to 69%. Exception reporting for this indicator was previously 16% and had also dropped to 7.9%. At the time of our inspection, the practice was unable to explain this decline in performance. However, following our inspection we were provided with an update to explain the decline in performance which was due to the practice not having an effective process in place to ensure the continual monitoring of QoF performance in the absence of staff members responsible for this task.

## 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) (to) NHS England) England)   | 51        | 51          | 100.0%     | Met 95% WHO based target |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (to) (NHS England) England)   | 40        | 40          | 100.0%     | Met 95% WHO based target |
| 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) (to) (NHS England) England)   | 40        | 40          | 100.0%     | Met 95% WHO based target |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (to) (NHS England)   | 38        | 40          | 95.0%      | Met 95% WHO based target |
| <b>Any additional evidence or comments</b>   |           |             |            |                          |
| <p>We saw that the practice nurse maintained an effective system for ensuring children were receiving vaccinations. The nurse had worked at the practice for a significant length of time and had developed a professional rapport with patients. We were informed that this was a complimentary factor in enabling the practice to maintain high childhood immunisation rates as she was able to follow up on individual patients and whilst offering assurance, encourage compliance from parents and guardians.</p> |           |             |            |                          |

Working age people (including those recently retired and students)

| Cancer Indicators  |          |             |                 |                         |
|--|----------|-------------|-----------------|-------------------------|
| Indicator  | Practice | CCG average | England average | England comparison      |
| The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2016 to 31/03/2017) (Public Health England) | 65.7%    | 71.7%       | 72.1%           | No comparison available |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE)  | 67.6%    | 74.3%       | 70.3%           | N/A                     |
| Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE)  | 62.0%    | 53.7%       | 54.5%           | N/A                     |
| The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (PHE)  | 60.0%    | 64.2%       | 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)  | 63.6%    | 56.2%       | 51.6%           | No comparison available |
| <b>Any additional evidence or comments</b><br><br>We reviewed unverified QoF data for the practice's performance in relation to cervical screening in the year 2017/2018. This data appeared to have improved to 75%, in line with local and national averages.                            |          |             |                 |                         |

People experiencing poor mental health (including people with dementia)

| Mental Health Indicators   |  |                    |                        |                         |
|--|--|--------------------|------------------------|-------------------------|
| Indicator  | Practice                                       | CCG average        | England average        | England comparison      |
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF) | 27.3%  | 86.6%              | 89.5%                  | No comparison available |
| QOF Exceptions   | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                         |
|  | 0 (0)  | 18.2%              | 12.7%                  |                         |
| 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 (01/04/2017 to 31/03/2018) (QOF)                          | 68.2%  | 91.1%              | 90.0%                  | No comparison available |
| QOF Exceptions   | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                         |
|  | 0 (0)  | 16.7%              | 10.5%                  |                         |
| 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 (01/04/2017 to 31/03/2018) (QOF)  | 100.0%   | 84.9%              | 83.0%                  | No comparison available |
| QOF Exceptions   | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                         |
|  | 25.0% (2)                                      | 7.1%               | 6.6%                   |                         |

### Any additional evidence or comments

We reviewed data for the Quality and Outcomes framework 2016/2017 in comparison to the 2017/2018 data and found that performance for these indicators appeared to have fallen as follows:

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 83%, now 27% compared to a local average of 86% and national average of 90%. Exception reporting for this indicator was 0%.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months was 89%, now 68% compared to a local average of 91% and national average of 90%. Exception reporting for this indicator was 0%.

Performance for dementia care had improved:

- The percentage of patients diagnosed with dementia whose care plan had been reviewed in a face-to-face review in the preceding 12 months was previously 89%, is now 100% compared to a local average of 85% and national average of 83%. Exception reporting for this indicator was 25%.

The practice advised that there was no care planning for mental health patients and no recall system established. The practice advised that local care systems for mental health were also limited with long waiting times for appointments with support services and limited consultant appointments.

### Monitoring care and treatment

| Indicator                              | Practice | CCG average      | England average |
|--|----------|------------------|-----------------|
| Overall QOF score (out of maximum 559) | 498      | Data Unavailable | 537.5           |
| Overall QOF exception reporting        | 5.8%     | Data Unavailable | 10.1%           |

### Coordinating care and treatment

| Indicator  | Y/N |
|--|-----|
| The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2016 to 31/03/2017) (QOF) | Yes |

### Helping patients to live healthier lives

| Indicator  | Practice | CCG average | England average | England comparison      |
|--|----------|-------------|-----------------|-------------------------|
| The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose | 94.4%    | 94.8%       | 95.3%           | No comparison available |

|   |  |                    |                        |  |
|---|--|--------------------|------------------------|--|
| notes record smoking status in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF) |  |                    |                        |  |
| QOF Exceptions  | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |  |
|   | 1.4% (10)                                      | 0.9%               | 0.8%                   |  |

## Consent to care and treatment

| Description of how the practice monitors that consent is sought appropriately   |
|---|
| <p>Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.</p> <p>When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.</p> <p>Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.</p> <p>We were advised that written consent forms were used for specific procedures as appropriate in the practice, for example for contraceptive device fittings.</p> |



# Caring

## Kindness, respect and compassion

| CQC comments cards  |       |
|---|-------|
| Total comments cards received   | 42    |
| Number of CQC comments received which were positive about the service | 39    |
| Number of comments cards received which were mixed about the service  | Three |
| Number of CQC comments received which were negative about the service | None  |

Examples of feedback received:

| Source                    | Feedback   |
|---------------------------|--|
| Comments cards.           | Patients commented that they found the staff at the practice to be friendly, helpful and polite. Practice staff were praised for the high level of care and support patients felt they received. Three patients commented on the lack of continuity of care available at the practice with regard to GP care; these comments were made alongside positive comments on the standard of care received.   |
| Interviews with patients. | We spoke with two patients during our inspection and both advised that they found staff were friendly, professional and accommodating to patient requests. Patients told us that GPs and nurses were good at listening to their concerns and informing them of the treatment options available to them. Patients told us they felt they were given adequate time in appointments and that the standard of care was good. One patient commented on the lack of continuity of care from GPs. |

## 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 |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 3,900                    | 305              | 91               | 30%                   | 2%                       |

| Indicator  | Practice | CCG average | England average | England comparison    |
|--|----------|-------------|-----------------|-----------------------|
| The percentage of respondents to the GP patient survey who stated that the last time | 86.4%    | 85.1%       | 89.0%           | Comparable with other |

| Indicator   | Practice | CCG average | England average | England comparison              |
|---|----------|-------------|-----------------|---------------------------------|
| 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)  |          |             |                 | 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) | 84.6%    | 82.3%       | 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)                              | 93.2%    | 93.0%       | 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)   | 80.8%    | 77.4%       | 83.8%           | Comparable with other practices |
| <b>Any additional evidence or comments</b>  |          |             |                 |                                 |

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

| Any additional evidence   |
|---|
| The practice sought patient feedback by utilising the NHS Friends and Family test. The NHS Friends and Family test (FFT) is an opportunity for patients to provide feedback on the services that provide their care and treatment. The practice advised that feedback received was largely positive. Although we saw that FFT forms had been completed the practice did not provide a summary of the most recent results during our inspection. |

## Involvement in decisions about care and treatment

Examples of feedback received:

| Source                    | Feedback   |
|---------------------------|--|
| Interviews with patients. | We asked patients whether they felt they were involved in decisions about their care and treatment. We were told they found the GPs and nurses were good at ensuring their personal decisions were considered when discussing treatment options. |

## 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) | 87.9%    | 89.4%       | 93.5%           | Comparable with other practices |
| <b>Any additional evidence or comments</b>   |          |             |                 |                                 |

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

| Carers   | Narrative  |
|--|--|
| Percentage and number of carers identified           | The practice had identified 37 patients who were carers (1% of the practice list).   |
| How the practice supports carers                     | There was a carers form and information board available in the practice. All patients identified as carers were signposted to the local carers charity, MK Carers. The practice had a dedicated carers champion who acted as a point of contact for carers and their families. |
| How the practice supports recently bereaved patients | Staff told us that if families had suffered bereavement, a GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.                |

## Privacy and dignity

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

|  | Narrative   |
|--|---|
| Arrangements to ensure confidentiality at the reception desk | The practice waiting area was situated away from the reception desk. We saw that due to the shared premises, patients awaiting other services were situated opposite the reception desk. Staff advised us that they did not disclose personal identifiable information when speaking to patients on the telephone and that they spoke quietly when needed. Staff advised they could take patients to a confidential area to provide additional privacy if needed. The practice also had a self-check-in facility to further improve confidentiality for patients waiting to speak to reception staff. |

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

Examples of specific feedback received:

| Source                    | Feedback   |
|---------------------------|--|
| Interviews with patients. | Patients told us they felt their privacy was respected and if they needed to discuss something privately with reception, staff would facilitate this by talking quietly or inviting patients into a separate area. |
| Interviews with staff.    | Staff told us that patients suffering from contagious conditions, those with particularly distressing conditions or those requesting privacy had access to a private room to wait to be seen.                      |

# Responsive

## Responding to and meeting people's needs

| Practice Opening Times |               |
|------------------------|---------------|
| Day                    | Time          |
| Monday                 | 8am to 6.30pm |
| Tuesday                | 8am to 6.30pm |
| Wednesday              | 8am to 6.30pm |
| Thursday               | 8am to 6.30pm |
| Friday                 | 8am to 6.30pm |

|                        |   |
|------------------------|---|
| Appointments available |   |
|                        | Appointments were available daily from 8.30am to 4.30pm with a GP and from 9am till 6pm with a nurse. |
| Extended hours opening |   |
|                        | The practice did not offer any extended hours appointments.   |

| Home visits   | Y/N |
|---|-----|
| The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention   | Yes |
| If yes, describe how this was done  |     |
| Patients were able to telephone the practice to request a home visit and a GP would call them back to make an assessment and allocate the home visit appropriately. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff we spoke with were aware of their responsibilities when managing requests for home visits. |     |

## National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 3,900                    | 305              | 91               | 30%                   | 2%                       |

| Indicator  | Practice | CCG average | England average | England comparison    |
|--|----------|-------------|-----------------|-----------------------|
| The percentage of respondents to the GP patient survey who stated that at their last | 89.1%    | 93.2%       | 94.8%           | Comparable with other |

| Indicator   | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------|
| general practice appointment, their needs were met (01/01/2018 to 31/03/2018) |          |             |                 | practices          |
| <b>Any additional evidence or comments</b>                                    |          |             |                 |                    |

## Timely access to the service

National GP Survey results

| Indicator   | Practice | CCG average | England average | England comparison              |
|---|----------|-------------|-----------------|---------------------------------|
| The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018) | 83.9%    | 58.4%       | 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)                             | 83.6%    | 59.5%       | 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)                    | 76.9%    | 61.9%       | 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)                     | 84.5%    | 68.6%       | 74.4%           | Comparable with other practices |
| <b>Any additional evidence or comments</b><br>Staff and patients we spoke with informed that appointment accessibility was good at the practice and that wait times were minimal.         |          |             |                 |                                 |

Examples of feedback received from patients:

| Source          | Feedback  |
|-----------------|---|
| Comments cards  | Out of the 42 cards received, there were no negative comments in relation to appointment access. Three patients commented specifically on not being able to see the same doctor. This was recognised by the practice as being due to the practice's reliance on locums and the salaried GP only attending the practice once a week. |
| Interviews with | We spoke with two patients during our inspection, both advised they were able to  |

|          |                               |
|----------|-------------------------------|
| patients | get appointments when needed. |
|----------|-------------------------------|

### Listening and learning from complaints received

| Complaints   | Y/N   |
|--|-------|
| Number of complaints received in the last year.  | Three |
| Number of complaints we examined   | Three |
| Number of complaints we examined that were satisfactorily handled in a timely way  | Three |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman  | 0     |
| <b>Additional comments:</b>  |       |
| <ul style="list-style-type: none"> <li>The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and made improvements. For example, we saw that following receipt of a complaint regarding a blood test the practice produced an information leaflet for patients.</li> <li>However, evidence of shared learning was limited as the practice did not routinely discuss all complaints with staff. We saw that the practice had updated its meeting agenda template to incorporate complaints as a standing item for future meetings. There was no routine analysis of complaints to identify trends.</li> </ul> |       |

# Well-led

## Leadership capacity and capability

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

We identified multiple concerns with regard to the leadership capacity and capability at the practice. We were informed that the salaried GP was available at the practice one day each week and that the provider had not been able to secure additional salaried GPs. Staff advised that the provider was not involved in the day to day running of the practice and maintained an arms-length approach to overseeing the practice.

We found that the practice manager did not have adequate resource to undertake the role effectively or safely. We found that the overall practice management of non-clinical duties needed improving. There was evidence of consistent failures to manage and respond to risk and to encourage improvement.

There was limited engagement in the inspection process from the practice as the practice did not complete the information request that we ask practices to return to the CQC prior to inspection.

## Vision and strategy

### Practice Vision and values

The provider did not have a documented vision and values for the practice. There was no information in the practice or on the website regarding this.

The staff we spoke with were not aware of the providers vision and values for the practice.

During our inspection the provider advised that they had recognised some areas in need of improvement, including the need to offer further management support to the practice manager. However, we were not shown any plans to overcome recognised challenges or to drive improvement.

## Culture

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

Although staff spoke positively about working at the practice, evidence to demonstrate a culture of high-quality sustainable care was limited. Staff did not receive regular appraisals and there was no system to support clinical supervision. We identified risks due to insufficient management oversight.

Failure to undertake appropriate risk assessments did not provide assurance that risks had been considered or mitigated.

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

| Source                     | Feedback   |
|----------------------------|--|
| Non-clinical staff members | Described relationships between managers and staff as being good, with on-site leaders being approachable and responsive. However, involvement and support |



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|--|--|
|  | provided by the provider organisation was unclear and pressures on the practice manager were described as excessive. |
|--|--|

## 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 range of policies available to support the delivery of good quality care however there was need for improvement. Policies in relation to risk management and the handling of safety alerts, complaints and incidents needed strengthening. |
| Other examples   | None.   |
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## Managing risks, issues and performance

| Major incident planning   | Y/N |
|---|-----|
| Major incident plan in place  | No  |
| Staff trained in preparation for major incident   | No  |
| Any additional evidence   |     |
| The business continuity plan was dated September 2015 and did not accurately reflect the practice situation. It had not been reviewed or updated since that time. |     |

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

| Risk                               | Example of risk management activities  |
|------------------------------------|--|
| Insufficient stable clinical team. | The provider organisation undertook a clinical analysis and identified several risks, for example in relation to medicines management. In response to these identified concerns the provider recruited an advanced nurse practitioner and secured three long term locum GPs. The practice also shared a practice pharmacist with another local practice to support effective medicines management. |

## Appropriate and accurate information

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

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

### Feedback from Patient Participation Group;

#### Feedback

The practice did not have Patient Participation Group (PPG). We were told that the practice was continuing with efforts to recruit a PPG but there had been very limited interest from patients. A patient feedback box was available in the waiting area for patients to make suggestions.

#### Any additional evidence

The provider did not undertake any staff surveys or have an established appraisal system. Staff informed us that the practice manager and salaried GP were approachable and would respond to any requests for training or support.

#### 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](#)).