Care Quality Commission

Inspection Evidence Table

Ravensbury Park Medical Centre (1-5163829957)

Inspection date: 18 September 2018

Date of data download: 30 July 2018

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

Safe

Safety systems and processes

Safeguarding	Y/N
There were lead members of staff for safeguarding processes and procedures.	Y
Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Policies were in place covering adult and child safeguarding.	Y
Policies were updated and reviewed and accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs)	Y
Information about patients at risk was shared with other agencies in a timely way.	Y
Systems were in place to highlight vulnerable patients on record. There was a risk register of specific patients	Y
Disclosure and Barring Service checks were undertaken where required	Y
Explanation of any 'No' answers: Evidence of at risk patients discussed in multidisciplinary team meeting minutes and also discussed with the health visiting team. The practice held a register for patients affected by or at risk of female genital mutilation (FGM).	

Recruitment Systems	Y/N
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y

Staff who require medical indemnity insurance had it in place	Y
Explanation of any answers: Regular locums were used and an agency were also used who carried out the appropriate pre-employment checks.	

Safety Records	Y/N
There was a record of portable appliance testing or visual inspection by a competent person Date of last inspection/Test: 5/3/2018	Y
There was a record of equipment calibration Date of last calibration: 7/6/2018 (and August 2018 for refrigerator thermometers).	Y
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals	Y
Fire procedure in place	Y
Fire extinguisher checks	Y
Fire drills and logs	Y
Fire alarm checks	Y
Fire training for staff	Y
Fire marshals	Y
Fire risk assessment Date of completion 1/8/2018	Y
Actions were identified and completed.	Y
Additional observations: Last fire drill was 30/7/2018	Y
Health and safety Premises/security risk assessment? Date of last assessment: 19/7/2018	Y
Health and safety risk assessment and actions Date of last assessment: 19/7/2018	Y
Additional comments: Lone working risk assessment included in the lone working policy which was reviewed 10/9/2018. Public and employer's liability was in place. Expiry date of policy was 12/3/2019 The lift was out of order on the inspection day and we were told it had not been working for three months. The practice was in discussion with the landlord regarding who was accountable for fixing this.	

Infection control	Y/N
Risk assessment and policy in place Date of last infection control audit: 24/8/2018 The practice acted on any issues identified Detail: The audit was undertaken by NHS England. There was one action which was to purchase a second independent thermometer for the vaccine refrigerators. This had been completed. The practice also carried out a six-monthly room audit to assess infection control equipment and waste disposal. This was last completed on 15/9/2018.	Y
The arrangements for managing waste and clinical specimens kept people safe?	Y
Explanation of any answers: The infection control policy and supporting policy documents had been reviewed in July 2018. They were detailed and appropriate.	

Any additional evidence
A Legionella risk assessment was undertaken 29/8/2018/ No risk was detected and there were no actions outstanding.

Risks to patients

Question	Y/N
There was an effective approach to managing staff absences and busy periods.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans were developed in line with national guidance.	Y
Staff knew how to respond to emergency situations.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
In addition, there was a process in the practice for urgent clinician review of such patients.	Y
The practice had equipment available to enable assessment of patients with presumed sepsis.	Y
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
Explanation of any answers: The practice used three regular locum GPs. Locum packs were detailed and thorough. The practice manager met with the locum GP to provide and induction before they started working with patients.	

Reception staff in additional to clinical staff had undertaken training in sepsis.
There was a clear 'emergency call handling protocol' for reception staff to follow.

The business continuity plan was available off site and also on the cloud-based intranet system. There were clear arrangements with a buddy practice.

Information to deliver safe care and treatment

Question	Y/N
Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
The practice had a documented approach to the management of test results and this was managed in a timely manner.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y

Explanation of any answers:

Improvements had been made following incidents that had been reported and investigated relating to the management of referrals and results.

- The practice now had a spreadsheet of all urgent two-week referrals and a clear process to ensure patients had been seen.
- A back up system was in place for the management of correspondence and results. The practice manager had oversight of all clinicians' inboxes to ensure results and letters were actioned. There were no outstanding results awaiting review beyond 17/9/18.
- The practice had a clear system to monitor that results were received for every cervical smear taken and all inadequate samples had been actioned.

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).(01/07/2016 to 30/06/2017)(NHS Business Service Authority - NHSBSA)	1.00	0.81	0.98	Comparable to other practices
Percentage of antibiotic items prescribed that are Co-Amoxiclav, Cephalosporins or Quinolones.(01/07/2016 to 30/06/2017) (NHSBSA)	6.8%	11.1%	8.9%	Comparable to other practices

Medicines Management	Y/N
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	Y
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, audits for unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were systems for the safe ordering, checks on receipt, storage, administration, balance checks and disposal of these medicines in line with national guidance.	N/A
Up to date local prescribing guidelines were in use.	Y
Clinical staff were able to access a local microbiologist for advice.	Y
For remote or online prescribing there were effective protocols in place for identifying and verifying the patient in line with General Medical Council guidance.	N/A
The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen on site.	Y
The practice had a defibrillator.	Y
Both were checked regularly and this was recorded.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	Y

Explanation of any answers:

At the last inspection, there were concerns with high risk medicines prescribing due to lack of monitoring of patients. During this inspection, we found that the practice was following prescribing protocols for high risk medicines and two audits had been triggered to check patients were being monitored appropriately.

The practice held appropriate emergency medicines for their population and for the services offered, however there was no documented risk assessment to outline the decision. The practice sent a detailed and considered risk assessment immediately following the inspection.

Emergency medicines and equipment were monitored weekly.

A review of vaccine refrigerator temperature logs showed that there were three missed days in August 2018. Staff told us this was because there had not been arrangements for the temperature to be checked when the nursing team were on leave or off site. The practice had identified this ahead of the inspection and trained reception staff. Since this had been rectified, the temperature records were in line with vaccine management guidance.

Track record on safety and lessons learned and improvements made

Significant events	Y/N
There was a system for recording and acting on significant events	Y
Staff understood how to report incidents both internally and externally	Y
There was evidence of learning and dissemination of information	Y
Number of events recorded in last 12 months.	8
Number of events that required action	8

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

Event	Specific action taken
Delayed referral due to incorrect referral form used and incorrect email address used by admin staff	Complaint which was investigated as a significant event. The practice ensured all staff were aware of the correct referral procedure to follow and all staff completed information governance training.
Wrong diagnosis coded on a patient's records	Discussed in a practice meeting and the GP completed information governance training.
Not following the prescribing protocol for prescribing a high-risk medicine	All affected patients were contacted and blood tests arranged. Audits of prescribing for two high risk medicines were commenced in December 2017.

Safety Alerts	Y/N
There was a system for recording and acting on safety alerts	Y
Staff understand how to deal with alerts	Y

Comments on systems in place:

There was a lead GP for dealing with and acting on safety alerts. Alerts were all logged on the practice's cloud-based intranet system. The practice ran searches for patients that could be affected by alerts; we saw two examples of this.

Alerts were discussed in clinical meetings which were attended by doctors and nurses. The practice manager had oversight over the system including actions carried out by clinical staff as a result of alerts.

Any additional evidence
The practice had identified eight incidents over the last 12 months and all of these required action. This was due to a number of incidents from issues highlighted at the last inspection, including an information governance breach and lack of systems to monitor inboxes containing results and correspondence when staff were on leave. All eight incidents had been acted on and actions were completed. One incident had occurred that was not recorded on the practice's incident log. For example, staff told us that a patient had been given the wrong immunisation. This was reported, recorded on an incident form and discussed with staff but was not on the central log of incidents.

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). (01/07/2016 to 30/06/2017) (NHSBSA)	0.51	0.66	0.90	Comparable to 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)	67.4%	72.5%	79.5%	Comparable to other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	7.0% (27)	10.0%	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)	54.9%	72.2%	78.1%	Significant Variation (negative)
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	9.8% (38)	8.0%	9.3%	
Indicator	**Practice performance**	**CCG average**	**England average**	**England comparison**
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2016 to 31/03/2017) (QOF)	69.2%	73.7%	80.1%	Comparable to other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	10.1% (39)	10.5%	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. (01/04/2016 to 31/03/2017) (QOF)	73.6%	73.7%	76.4%	Comparable to other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	2.9% (7)	3.8%	7.7%	
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of patients with COPD who had a review undertaken 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)	88.7%	90.0%	90.4%	Comparable to other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	0 (0)	7.2%	11.4%	
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (01/04/2016 to 31/03/2017) (QOF)	74.5%	79.1%	83.4%	Variation (negative)
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	6.2% (45)	3.5%	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)	88.9%	86.2%	88.4%	Comparable to other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	8.2% (4)	8.7%	8.2%	

Any additional evidence or comments

Additional diabetes evidence

2017/18 QOF unverified data for Diabetes

- Unverified data for 2017/18 QOF showed that overall diabetes achievement was 82.8% (71.23 points out of 86 points) compared with overall diabetes achievement of 64.86% in 2016/17.
- 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 was 79.1%.
- 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 was 53.8%.
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less was 80.8%.

The practice reported factors affecting patient engagement with diabetes management:

- Diabetes prevalence was higher than local and national averages (2016/17 data showed that prevalence was 9.8% compared with a CCG average of 6.1% and national average of 6.7%).
- The practice had difficulty getting patients to respond to invitations and reminders for reviews.
- Some patients from with diabetes spent a large proportion of the year abroad in their countries of origin, resulting in difficulties targeting these patients for reviews.

Additional hypertension evidence

2017/18 QOF unverified data for hypertension

- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less was 73% for 2017/18.

Families, children and young people

Child Immunisation				
Indicator	**Numerator**	**Denominator**	**Practice %**	**Comparison to WHO target**
Percentage of children aged 1 with completed primary course of 5:1 vaccine. (01/04/2016 to 31/03/2017) (NHS England)	60	66	90.9%	Met 90% Minimum (no variation)
The percentage 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)	57	63	90.5%	Met 90% Minimum (no variation)

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)	58	63	92.1%	Met 90% Minimum (no variation)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (first dose of MMR) (01/04/2016 to 31/03/2017) (NHS England)	59	63	93.7%	Met 90% Minimum (no variation)

Any additional evidence or comments

The practice reported they had a system of three recalls for childhood immunisations and they followed up non-attenders of childhood immunisations via phone calls and escalation to local health visiting teams where indicated. The practice reported they now had a more stable nursing staffing team, which had improved uptake.

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 who were screened adequately 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)	71.6%	67.3%	72.1%	Comparable to other practices
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) **(PHE)**	66.8%	66.9%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)**(PHE)**	44.4%	48.9%	54.5%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. **(PHE)**	72.7%	75.7%	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)	45.0%	54.8%	51.6%	Comparable to other practices

Any additional evidence or comments

The practice reported they now had a system to follow up non-attenders of cervical screening via text message and letters plus they had a more stable nursing staffing team, which had improved uptake.

People experiencing poor mental health (including people with dementia)

Mental Health Indicators				
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	83.3%	88.8%	90.3%	Comparable to other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	23.1% (9)	8.9%	12.5%	
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	91.2%	86.5%	90.7%	Comparable to other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	12.8% (5)	6.7%	10.3%	
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	80.0%	81.7%	83.7%	Comparable to other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	11.8% (2)	5.2%	6.8%	

Any additional evidence or comments

There were 24 patients on the practice's dementia register.

2017/18 QOF unverified data

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 was 94%.

Monitoring care and treatment

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	511	521	539
Overall QOF exception reporting	5.6%	5.2%	5.7%

Any additional evidence
Overall QOF score was 95.7% for 2017/18 (unverified); 91.4% for 2016/17 and 85.1% for 2015/16. **CCG benchmarking data for antibiotic prescribing** Oral antibiotic prescribing from June 2016 to June 2017 showed the practice were the 6th highest prescriber in the CCG although prescribing had reached the CCG target and reduced compared to the previous year. Data also showed they were the second best performing practice in the CCG for the percentage of antibiotic items that were broad spectrum antibiotics. See the list of audits and quality improvement projects under Well-led, 'Continuous improvement and innovation'.

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 physical and/or mental health conditions whose notes record smoking status in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	96.4%	94.1%	95.3%	Comparable to other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	0.9% (10)	0.5%	0.8%	

Consent to care and treatment

Description of how the practice monitors that consent is sought appropriately
Records audits were undertaken which included the monitoring of consent.

Any additional evidence

No written consent was required for medical procedures provided at the practice. Consent was recorded in templates used by clinical staff, for example for cervical screening and immunisations.

Evidence of a mental capacity assessment was seen in patient records.

Caring

Kindness, respect and compassion

CQC comments cards	
Total comments cards received	18
Number of CQC comments received which were positive about the service	18
Number of comments cards received which were mixed about the service	0
Number of CQC comments received which were negative about the service	0

Examples of feedback received:

Source	Feedback
Comments Cards	Patients reported that they were always treated with respect, they were listened to and provided with the right care and treatment. Patients reported that reception staff and doctors were welcoming, friendly, professional and efficient.
Patient interview	Five patients were spoken to. All patients reported they were treated with dignity and respect. Two patients reported that some GPs did not have time to listen however patients reported that one of the partners always listened and gave them time.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5,339	343	99	28.9%	1.8%

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)	88.4%	86.9%	89.0%	Comparable to 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)	86.0%	83.5%	87.4%	Comparable to other practices

The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to(01/01/2018 to 31/03/2018)	92.9%	93.8%	95.6%	Comparable to 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)	80.3%	81.7%	83.8%	Comparable to other practices
Any additional evidence or comments				

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

Date of exercise	Summary of results
March-August 2018	NHS Friends and Family Test results showed that on average 96.5% of patients would recommend the practice.
April-July 2018	The Patient Participation Group (PPG) practice survey results showed that 93% of patients felt the last nurse they saw was good at listening to them. 91% of patients felt the nurse treated them with care and concern and 92% felt they had confidence and trust in the last nurse they saw. 81% of patients felt the overall experience at the surgery was good or very good.

Involvement in decisions about care and treatment

Examples of feedback received:

Source	Feedback
Interviews with patients	One patient explained how one of the partners provided them with considerable time and care to support them with a bereavement.
Comments cards	All cards were positive about the standard of care delivered. Patients reported that they were provided with information about the right care and treatment, including those with long-term conditions. A patient commented that reception staff printed off the online appointment booking form for them.

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)	86.9%	91.1%	93.5%	Comparable to other practices

Any additional evidence or comments

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

Carers	Narrative
Percentage and number of carers identified	The practice has increased the carers register from 2 to 65 over the last two years. This equates to 1.2% of the practice list size.
How the practice supports carers	Carer flu immunisations and health checks were promoted via text alert, recalls and they advertise on the website and in the waiting room. Staff were able to refer to a weekly social prescribing service. The head of reception was also the care co-ordinator who maintained the register and used pop-up alerts on the electronic record system to identify where patients were acting as carers.
How the practice supports recently bereaved patients	Relatives were sent sympathy letters and appointments were offered. Relatives and patients were signposted to bereavement counselling services locally.

Any additional evidence

There was evidence that some reception staff had undertaken training in the Accessible Information Standard.

The PPG reported that the practice had increased the amount of information about local services and support in the reception area.

The hearing loop in reception was not working but the practice used text messages or email to communicate with those with hearing impairments.

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	Staff were able to use a private room adjacent to the reception desk for private or sensitive conversations. Reception staff were aware to use a patient's date of birth to identify them and to get the patient to state their own name.

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
Comment cards	All comments were positive about staff treating them with dignity and respect.
Observation	Chaperone policy notices were available in clinical rooms and the waiting area.

Responsive

Responding to and meeting people's needs

Practice Opening Times	
Day	**Time**
Monday	8am-7pm
Tuesday	8am-8pm
Wednesday	8am-8.30pm
Thursday	8am-7pm
Friday	8am-7pm

Appointments available

Appointments were available between 8am and 6.30pm Monday to Friday.

Urgent appointments

Urgent patients were seen on the same day. Reception staff were able to book directly into emergency appointment slots. Once fully booked, doctors offered telephone triage and additional appointments were added if necessary.

There were dedicated emergency slots for children both in the morning and the afternoon, daily.

There was an on-call nurse service between 8am and 6.30pm.

We saw that there were a number of emergency appointments still available on the inspection day.

Same day appointments

The majority of appointments offered were same day appointments. Patients were able to call on the day or book online. On the inspection day same day appointments were available.

Pre-bookable appointments

Pre-bookable appointments could be booked up to two months in advance for GPs and nurses. appointments. These could be booked by the telephone or online. On the inspection day we saw that routine appointments were available within two days.

A clinical pharmacist offered appointments for diabetes patients from 9am to 4.30pm on Fridays; phlebotomy appointments were available daily with practice nurses and social prescribing appointments were available weekly.

Extended hours opening

Pre-bookable appointments were available during extended hours on Tuesday from 6.30pm-7.30pm and Wednesday 6.30pm-8pm.

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	
All home visit requests were allocated to the on-call doctor. The on-call doctor provided a telephone triage appointment ahead of visiting patients at home.	

Timely access to the service

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5,339	343	99	28.9%	1.8%

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)	92.8%	94.0%	94.8%	Comparable to other practices
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	70.5%	65.2%	70.3%	Comparable to 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)	74.3%	66.7%	68.6%	Comparable to 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)	67.0%	67.3%	65.9%	Comparable to 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)	74.2%	72.7%	74.4%	Comparable to other practices

Any additional evidence or comments

The Patient Participation Group (PPG) practice survey results for April-July 2018, which surveyed 16 patients, showed that 68% said it was very easy or fairly easy to get through to someone using the telephone; 63% felt they could speak or see their GP of choice always or a lot of the time and 70% said their experience of making an appointment was very good or fairly good.

Following the previous GP patient survey results, previous practice survey results and on-going review of appointment demand and capacity, the practice increased their appointment times to start at 8am rather than 9am over the last 12 months. They had also increased GP appointments on Mondays due to increased demand on these days.

During the inspection, reception staff announced to patients in the waiting area that appointments were delayed.

Examples of feedback received from patients:

Source	Feedback
Patient interviews	Of five patients spoken to, four patients reported it was difficult to get an appointment. They reported there were not many appointments available online and when they called for same day appointments it was difficult to get through on the telephone. Patients also reported that it was common to experience delays, where appointments overran.
Comments cards	All 18 cards were positive about appointments. Patients stated they could get appointments when they needed them, with their GP of choice. One patient stated that the surgery called to remind them when childhood immunisations were due. Patients reported they liked the flexibility of online appointment booking.

Listening and learning from complaints received

Complaints	Y/N
Number of complaints received in the last year.	4
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:	
We identified that there were clear audit trails and timely responses for each complaint, but we found that there were some additional issues stemming from complaint investigations that required follow up to ensure that all concerns resulting from complaints had been reviewed. The practice acted on these areas immediately after the inspection and updated their complaints procedure to reflect that full investigation and analysis were required.	

Example of how quality has improved in response to complaints
Following a complaint about a delayed referral and the incorrect referral procedure used, the practice ensured staff were aware of the correct referral procedure and all staff completed information governance training. The complaint was also investigated as a significant event.

Any additional evidence
Shortly following the inspection, the practice reviewed the online appointment access settings and rectified an issue that had caused limited appointments to be viewed online.

Well-led

Leadership capacity and capability

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

The leadership and management team had influenced a number of positive changes since the previous inspection of the practice in September 2017. The focus had been on areas of high priority to ensure safety and quality was improved.
Improvements shared by staff included:

- Recruitment of additional administrative staff and a clinical pharmacist to provide a more stable workforce.
- Training for existing staff including practice management training and sepsis training.
- Improved use of software and technology to support improved governance, for example using a cloud-based intranet system and improved patient record system templates.
- Improved support systems for staff and a clearer organisational structure.
- Tightened and renewed systems for managing and monitoring patient information including results, correspondence, referrals and recalling patients for reviews.
- Quality improvement projects and better performance data including for diabetes, cervical screening, childhood immunisations and antibiotic prescribing.
- Development of a new Patient Participation Group (PPG).
- An increase in clinical sessions at times of increased demand and promotion of online appointments.

Future priorities for the service included:

- Recruitment of a compliance manager and additional partners to change and develop the leadership and management team.
- Recruitment of a phlebotomist and health care assistant to increase nursing time.
- Improved policies and procedures.
- Engaging patients to attend for reviews and educating them to take responsibility for their health needs.
- Reducing non-attenders.
- Working at scale and collaborating with local services.

Leaders were aware that the long-term vision of the partnership structure needed to ensure quality could be sustained long-term.

Any additional evidence

Leadership was provided by the GP partners, managing partner and practice manager. Staff told us that two GP partners and the managing partner under the new provider arrangement had reduced their presence in the practice over recent months and assumed ongoing roles in coaching and mentoring, advising and supporting the practice manager and other two GP partners who had key roles in day to day leadership and operations at the practice.

Vision and strategy

Practice Vision and values
Staff were aware that the vision of the practice was to expand its patient list and services offered and increase collaborative work in the community. The practice motto was ‘quality, innovation and collaboration.’ The practice’s statement of purpose included the vision: “Our vision is that of a provider truly embedded within the population we serve building resilience in our local communities and improving their health and well-being. To achieve this we must work in partnership with patients, carers and key stakeholders across our local health system including other providers, the CCG and voluntary sector.”

Culture

Examples that demonstrate that the practice has a culture of high-quality sustainable care
Appraisals occurred annually for all staff. Learning and development was prioritised and encouraged. Staff were encouraged to attend role-specific training for example: • Diabetes management • Sepsis • Practice management The practice had introduced more support for the nursing team which included a monthly nurses meeting with a GP acting as a clinical supervisor, to provide a forum to discuss complex cases and to monitor practice performance in relation to cervical screening and childhood immunisations. Staff well-being was reviewed. A service was procured which included access to counselling. A daily coffee debrief session was held after morning surgery as a forum for peer support and to identify any arising issues.

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

Source	Feedback
Staff interviews	Since the previous inspection, staff outlined a number of positive changes: • Safer culture • Better checks and electronic trails • Administrative staffing has become more stable • Clinical staffing had become more stable • Better reporting and learning from incidents • The culture was more open • Staff worked more as a team • There was more clarity in practice systems and processes • A culture of learning and development was more evident

	Staff reported they felt valued and respected and they received adequate support. Some staff observed that some staff within the new provider arrangement in leadership and managerial roles did not always work cohesively, however there was little evidence this had impacted on the quality and safety of the service as decisions made had resulted in a number of improvements. We received no negative comments from employees about the change in culture in the practice.

Any additional evidence

Governance arrangements

Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care.	
Practice specific policies	Safeguarding adults and children, Duty of Candour, complaints, incident reporting, prescription security procedure, prescribing protocol, infection control policy and supporting procedures, lone working policy, whistleblowing. Policies were all available on the cloud-based intranet system.
Other examples	There was a structure of meetings to allow for information to be cascaded to staff: • Fortnightly management meetings • Monthly reception and admin meetings • Monthly nurses' meetings • Whole practice meeting • Bi-monthly clinical meetings • A range of multidisciplinary meetings All meeting minutes we viewed contained adequate information and action points to support good governance.

	Y/N
Staff were able to describe the governance arrangements	Y
Staff were clear on their roles and responsibilities	Y

Any additional evidence
There was evidence that staff felt the service had become more organised; the governance arrangements and organisational structure were more defined. Clinical governance systems had improved. Arrangements included: • Systems for daily peer support. • Clinical leads for key QOF areas of performance. • Clinical supervisor for nursing staff.

- Quality improvement projects including clinical audit.
- Structured clinical meetings

However, there were some areas of governance that required a review to support high quality care. For example:

- The system for monitoring verbal concerns and complaints was not being utilised.
- Issues arising from complaints had not been fully investigated in some cases. The complaints handling policy and identified issues were addressed after the inspection.
- The central resource for reception staff to refer to for key day to day information and protocols was dated 2016; the guidance had not been updated although a number of systems had changed since 2016. Staff were not able to locate an electronic copy of the reception protocols.
- There had been gaps in the governance system for monitoring vaccine refrigerator temperatures, although this had been identified ahead of the inspection. This was specifically linked to lack of arrangements to delegate tasks when nursing staff were on leave.

Managing risks, issues and performance

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

Examples of actions taken to address risks identified within the practice

Risk	Example of risk management activities
Lack of oversight of governance and risk systems from the previous inspection	More structured meeting arrangements and organisational chart. Procurement of software package to enable cloud-based access to policies and procedures and in addition, an organisational dashboard so key areas of risk could be seen at a glance. For example, performance data and equipment and premises risks.
Broken lift	The practice was in the process of communicating with the landlord to fix this; it was unclear where accountability lay for lift maintenance and repair.
One thermometer used to measure vaccine refrigerator temperatures	Infection control audit identified the need for a second thermometer for the vaccine refrigerators. These were purchased and were present on the inspection day.
Unclear workflow arrangements with regards to referrals, management of correspondence and results.	Workflow process issues were reported as significant events following the previous inspection and had been addressed and tightened. For example, there is a failsafe system for monitoring urgent two-week referrals. The cervical screening inadequacy rate and monitoring systems have been reviewed and were working effectively.
Unsafe high-risk medicines management systems	There was an overhaul of high risk medicines prescribing protocols and clinical audits to review high risk medicine prescribing.

Limited learning and improvement	Significant event, complaint and safety alerts policies and procedures were strengthened, supported by a clear audit trail of documents.
Lower performance in relation to long-term conditions	There was a clear and tailored clinical audit plan in response to performance data and concerns from the last inspection with evidence of a positive impact on performance data and patient outcomes, specifically for diabetes. A clinical pharmacist had been recruited to undertake diabetic reviews. The practice was aware of those areas of performance that still needed to be addressed, for example, hypertension.
Poor information governance arrangements identified from the previous inspection and significant events.	All staff training in information governance and confidentiality and discussions in staff meetings.
Lower uptake for cervical screening and childhood immunisations	Childhood immunisations and cervical screening data showed improvements. The nursing team has become more stable. There is a clinical supervisor for the nursing staff who attends the monthly nurses' meetings.
Lack of appointment availability	Following the previous GP patient survey results in 2017, previous practice survey results and on-going review of appointment demand and capacity, the practice increased their appointment times to start at 8am rather than 9am over the last 12 months. They had also increased GP appointments on Mondays due to increased demand on these days.

Appropriate and accurate information

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

Engagement with patients, the public, staff and external partners

Feedback from Patient Participation Group;

Feedback
<u>Meeting with PPG lead</u> • 8 meetings over the last 12 months, one per month since April 2018 when the PPG was revitalised. • A partner or the practice manager attended each meeting. • The practice had funded membership of the National Association for Patient Participation (NAPP) in order to obtain support and guidance for an effective PPG. • Able to speak to the practice manager at any time to raise concerns. • Clear objectives have been focussed on:

- May 2018 stall and coffee morning in foyer outside of practice entrance - handed out practice surveys
- NAPP awareness week June 2018
- July 2018 – PPG awareness stall and coffee morning and handed out practice surveys.
- Each coffee morning focussed on promotion of different services including flu immunisations, travel health and online services.

- Results of the 2018 practice survey had not been formally analysed and shared but initial results showed improvements compared with 2017 in relation to access to appointments.
- The PPG were turning their focus to support the practice with pushing for car park development for patients, using existing space that had been intended for this purpose.

Any additional evidence
Photographs of the coffee mornings and awareness stalls were seen. The PPG had a driven and motivated PPG lead and the group had a clear and tailored plan of events. The PPG event plan for 2018/19 was seen, which aligned with NHS events and awareness weeks. The practice had reviewed 2017 GP patient survey results, 2017 practice survey results and on-going review of appointment demand and capacity. They had made improvements including earlier session times in the morning and more appointments on Mondays. Results from the practice survey for April 2018-July 2018 had just been collated and were due to be discussed at the next PPG meeting. The practice gathered NHS Friends and Family Test (FFT) data. There had been 205 responses over the last 6 months from text message, written and online mediums; results showed that 96.5% of patients would recommend the practice.

Continuous improvement and innovation

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

Audit area	Improvement
Cervical smear audit 2013-2018	Four cycles reviewing inadequacy rates. Inadequacy rates have now reduced to 2.3% in 2018 (171 done; 4 were inadequate). First cycle in 2013 showed a 4.2% inadequacy rate; 3rd cycle in 2017 showed a 2.7% inadequacy rate
Methotrexate December 2017 to March 2018	Two cycles reviewing the practice's prescribing compliance with national safe prescribing guidance. First cycle of 14 patients showed 93% were on the recommended strength of methotrexate and 93% had up to date blood tests and 71% had a hand-held monitoring booklet. The practice set out a clear action plan including a tighter prescribing protocol. Second cycle showed improvements in all criteria to 100% compliance with safe prescribing guidance.

Cancer care July 2017	One cycle audit. Aimed to improve the cancer care register. There were 19 cancer diagnoses between Jan 2015 and Dec 2016. 13 had received a cancer case review within 6 months of diagnosis. An action plan was written to improve the cancer care register so it could be utilised to call patients for reviews.
Dementia Audit June 2017 and August 2018	Two cycle audit reviewing patients on the dementia register and current guidance. Results from the first cycle showed that 80% had carer and next of kin (NOK) details recorded and 75% had received a care plan review and 80% had received a flu jab. After the second cycle, 83% had recorded carer and NOK details in their records and 87% had care plan review and 92% had a flu jab. This showed improvements overall for monitoring and reviewing patients with dementia. The audit assisted in increasing the dementia register from 20 to 24.
Urinary Tract Infection (UTI) diagnostic audit	The practice compared current UTI diagnostic methods against PHE guidance and correct antibiotic dosage prescribed. The three cycle audit showed 72% compliance in 2016, 85% compliance at the second cycle and 90% compliance at the third cycle in 2017. There were improvements in the correct dose antibiotic prescribed from75% to 90% to 92% at the third cycle.
Sore throat antibiotic prescribing audit 2018	One cycle audit. Overall compliance with NICE antibiotic prescribing guidance was 95% but 0% compliance with primary care guidance in relation to course length prescribed.
Two-week referral rule December 2017- August 2018	The audit found that 100% of referrals were sent in 24 hours and 52% seen in 2 weeks at the first cycle. After the second cycle, 100% were sent in 24 hours and 87% seen in 2 weeks.

Any additional evidence

Engagement with local initiatives and quality improvements external to the practice had not been a priority over the last year as resources were directed at a range of quality improvement projects to improve internal systems and quality of practice services.

The practice had recently started being involved in a locally driven diabetes quality improvement project which consisted of a dedicated team to deliver diabetes care. This was in its infancy.

The practice had become a provisional member of a primary care home network, shadowing existing practices before engaging in collaborative work more actively.

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, a statistical tool which shows the deviation from the England average. It gives us a statistical measurement of a practice's performance in relation to the England average, and measures this in standard deviations. We calculate a z-score for each indicator, thereby highlighting the practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are +2 or more or -2 or less are at significant levels, warranting further enquiry.

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

The following language is used for banding variation:

- Significant variation (positive)
- Variation (positive)
- Comparable to other practices
- Variation (negative)
- Significant variation (negative)

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

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

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).