Care Quality Commission

Inspection Evidence Table

Hungerford Surgery (1-537624945)

Inspection date: 31 October 2019

Date of data download: 01 November 2019

Overall rating: Good

Please note: Any Quality and Outcomes Framework (QOF) data relates to 2018/19.

Safe Rating: Good

The practice was previously rated as Requires Improvement for providing safe services because:

- annual training of staff in basic life support and fire safety had not been undertaken;
- appropriate safeguarding training was not up to date for clinical staff in line with the practice policy;
- the practice had not sought appropriate assurances of the training records and conduct of locums prior to working at the practice;
- blank prescription stationery was not adequately monitored when in use;
- patient prescriptions which had been generated but not collected were not monitored in line with the practice's repeat prescribing policy.

At this inspection, we rated the practice as Good for providing safe services because:

- The practice was able to demonstrate improved monitoring of staff training and the practice sought alternative options for training when staff were unable to attend face to face training. This also included appropriate monitoring of training for locums.
- The practice had made changes to its blank prescription security and it was being logged and monitored in line with national guidelines.
- The practice had implemented a new process for uncollected prescriptions, with dedicated lead members of staff and we saw that patients who had not collected prescriptions were followed up.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes

Explanation of any answers and additional evidence:

The practice was aware of the January 2019 intercollegiate guidance regarding the level of child safeguarding training for both clinical and non-clinical staff. It was able to demonstrate that all practice nurses and the health care assistant/phlebotomist had completed the recommended level 3 for safeguarding training. However, one GP partner and a locum GP currently working at the practice had evidence of expired safeguarding adults and children training. The training had expired as of the beginning of October 2019. The practice told us both GPs had missed the recent safeguarding training day due to annual leave but it was able to demonstrate they were in the process of booking both GPs on a training session at another local practice. Following inspection, the practice provided evidence to demonstrate the GP partner and locum GP had completed necessary safeguarding training online and confirmed the date for the face to face safeguarding training at another local practice to be 6 November 2019.

We saw that nine administrative staff had not yet completed the recommended level 2 training for safeguarding children in line with January 2019 intercollegiate guidance. However, all staff had completed level 1 training and after the inspection the practice told us face to face level 2 training would be completed on 5 December 2019 by all administrative staff members.

The clinical pharmacist recently started working at the practice in September 2019 and the practice told us the clinical pharmacist would be completing level 3 safeguarding training at the earliest opportunity. The practice policy stated that training was required to be completed within six months of joining the practice. The practice was able to demonstrate the clinical pharmacist had completed level 2 training at

Safeguarding	Y/N/Partial
the time of inspection. The practice provided evidence it had submitted the Disclosing and Barring Service (DBS) application for the clinical pharmacist and was waiting for this to be completed. Until completion, the practice had an appropriate risk assessment in place and as the clinical pharmacist was still in their induction, the practice advised they were being supervised and would not carry out any one-to-one consultations until this had been completed. Staff we spoke to were able to clearly describe the process they would follow if they had any concern that patients were at risk of abuse and were all aware of the practice safeguarding lead.	

Recruitment systems	Y/N/Partial
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 if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Explanation of any answers and additional evidence: The practice was able to demonstrate all relevant recruitment checks had been completed for two staff members employed since the September 2018 inspection as well as a locum GP who had been working at the practice since January 2019. A clinical pharmacist had started in September 2019 within the Primary Care Network and the practice had led the recruitment process. We saw evidence that all recruitment checks had been completed in line with Schedule 3 of Health and Social Care Act 2008.	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 19 December 2018	Yes
There was a record of equipment calibration. Date of last calibration: 4 April 2019	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: 13 December 2018	Yes
There was a log of fire drills. Date of last drill: 22 October 2019	Yes
There was a record of fire alarm checks. Date of last check: 5 September 2019	Yes
There was a record of fire training for staff. Date of last training: October 2019	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 15 October 2019	Yes
Actions from fire risk assessment were identified and completed.	Yes

Explanation of any answers and additional evidence:

The recent fire risk assessment identified actions for the practice to carry out a fire evacuation drill with the practice team and to review some worn labels on equipment to ensure the next date for Portable Appliance Testing was clearly visible. The practice had completed both actions and the learning point of checking for persons in the upstairs staff room from the fire evacuation drill was shared with the team at a practice meeting on 24 October 2019.

We saw evidence that 13 staff members (both clinical and non-clinical) had completed fire marshal training since the last inspection in September 2018. The practice manager told us the designated fire marshal was usually the reception staff member at the front desk but to ensure this was clear to both staff and patients, the noticeboard in reception was regularly updated with the name of the fire marshal on duty that day.

The practice training policy stated that fire safety training was required every 12 months. When we reviewed the practice's Bluestream online training record, which had been shared and discussed within a practice meeting with all staff since the last inspection, we found that two staff members annual fire safety training had expired the day before inspection and had been reminded to complete this.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 16 November 2018	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 7 October 2019	Yes

Explanation of any answers and additional evidence:

An asbestos survey of the building was carried out in October 2018 following an action from a legionella risk assessment completed in November 2017. A further legionella risk assessment carried out in February 2019 confirmed actions relating to asbestos had been completed and highlighted an action for the practice to have their boilers serviced, which had been completed on 30 October 2019.

From the recent health and safety risk assessment 17 actions were identified. There was no immediate actions required but actions had been highlighted to be completed within six weeks and three months. These actions included:

- Driving and vehicle checks for staff members using a vehicle as part of their work activities. We saw the practice had commenced these checks for clinicians carrying out home visits.
- The practice's Health and Safety policy should be signed and dated by the overall responsible person. This had been completed by the practice on 7 October 2019.
- Competency checks for contactors should be requested and retained. The practice included this in their new 'Bright Safe health and safety policy' and told us that they would now take copies of identification checks for records.
- Removal or replacement of step ladders in line with commercial standards. We saw this had been completed and all ladders at the practice had been removed.
- Undergo another fire risk assessment to ensure all previous findings were suitably resolved. We saw the practice completed a new fire risk assessment on 15 October 2019 and all previous findings had been completed.
- Ensure the practice's new system 'Bright Safe' (a system to monitor health and safety in line with national standards) had all relevant policies and risk assessments. The practice had completed this.

We saw the practice had completed 14 actions and had commenced the final three actions which were due to be completed by 18 November 2019. The practice confirmed it had a follow up visit from an independent health and safety company booked for 4 December 2019.

The practice had recently introduced a new health and safety employee handbook for all new staff to be provided with to ensure all staff are informed of relevant policies and procedures.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: March 2019	
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes

Explanation of any answers and additional evidence:

The practice had a designated practice nurse for infection prevention and control (IP&C) responsibilities and all staff we spoke to could identify that individual as the lead.

The practice had an IP&C policy, which stated the IP&C training should be completed every 24 months by both clinical and non-clinical staff. The practice's Bluestream online training records showed that all staff were up to date with IP&C training in line with its policy.

The practice carried out regular audits for IP&C including handwashing technique. The last IP&C audit in March 2019 identified four actions for the practice, including changing the waste bin, window blind and chair within the Podiatrist room and changing the clinical waste bins in consultation rooms. All actions had been completed by July 2019.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	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.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes

Explanation of any answers and additional evidence:

The practice had recently introduced a human resources (HR) software system 'Bright HR' in October 2019 to manage and monitor staff rotas, staff absence and holiday entitlements in a single centralised system. The system had not yet been fully embedded, and the practice continued to use their previous system to manage HR in the interim.

The practice training policy stated that training for Basic Life Support (BLS) should be completed every 18 months for clinical staff and every 36 months for non-clinical staff. We saw evidence that all staff members had completed BLS training in line with the guidance and staff we spoke to were able to report how they would respond in an emergency.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	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 and additional evidence: The practice told us test results were referred to and monitored by patient's named GP or by the duty doctor in the named GP's absence. If there were any abnormal results, the GP would contact the patient directly to discuss. We saw evidence of test results having been reviewed and actioned appropriately.	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

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) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.88	0.77	0.87	No statistical variation
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). (01/07/2018 to 30/06/2019) (NHSBSA)	10.1%	9.3%	8.6%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) (NHSBSA)	5.88	5.47	5.63	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	1.80	1.81	2.08	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
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
There was a process for monitoring patients' health in relation to the use 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, investigation of 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 appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes

Explanation of any answers and additional evidence:

Since the last inspection in September 2018, the practice had reviewed and updated its prescription security protocol in line with national guidance. New procedures had been implemented, including the use of a new register to track and record prescriptions received and distributed to GPs. An administrator and the office manager shared the responsibility of managing and reviewing prescription security at the practice. The practice also carried out spot checks to ensure procedures were being appropriately followed. The practice could demonstrate prescriptions were being stored securely in line with national guidance.

The practice's policy on prescription security stated that it was advisable that GPs do not take blank

Medicines management	Y/N/Partial

prescriptions out on home visits due to the risk of theft or misplacing them. The NHS Counter Fraud national guidance advises that only a small number of prescription forms should be taken on home visits to minimise the potential loss. However, we found that GPs were taking a full blank prescription pad on home visits. We were assured these were kept in a locked bag and serial numbers were appropriately monitored.

We were told that uncollected prescriptions were checked on a regular basis and any found to be over one month old had been followed up with the patient. Following this, the practice would securely store uncollected prescriptions for a minimum of three months for auditing purposes and then they would be destroyed. On the day of inspection, we found one uncollected prescription dated back to September 2019, we saw evidence which demonstrated the practice had contacted the patient and made arrangements for the patient to collect the prescription from the surgery in due course.

During our inspection we found that a Patient Specific Direction (PSD) (which allow specified health professionals, such as appropriately trained Health Care Assistants, to supply or administer a specified medicine to a patient) had appropriate detail and authorisation for the practice's Health Care Assistant (HCA) to administer a specific medicine. However, we also found the HCA had signed a Patient Group Direction (PGD) (which allow specified health professionals, such as nurses, midwives and pharmacists, to supply or administer a medicine directly to a patient) for the same medicine. We saw no evidence the HCA gave medicines inappropriately. This was raised with the practice on the day of inspection and following inspection, the practice provided evidence that the HCA's details were removed from the PGD and had correctly signed the PSD.

The practice had appropriate emergency medicines available at the practice and these were regularly checked for expiry. The practice had risk assessed not having Dexamethasone (a medicine to treat croup in children) available as it was able to access this from the local pharmacy if required.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	20
Number of events that required action:	20

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

Event	Specific action taken
Breach of confidentiality – patient scan results sent to another practice.	The receiving practice was advised of significant event and requested information to be destroyed. Patient informed and apologised to. Reviewed and discussed at full staff meeting and correct procedure circulated to all staff.
Blood pressure (BP) result from the practice self-service BP machine left lying around and result had been unreported.	Discussed at full staff meeting. BP protocol reviewed and changes implemented to encourage patients to provide their results following use of blood pressure monitor.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes

Explanation of any answers and additional evidence:

The assistant practice manager was responsible for receiving and reviewing all safety alerts. The practice was registered to receive alerts through the appropriate central alerting system as well as through Electronic Checking Leading to Improved Prescribing Safety and Efficiency (ECLIPSE) within West Berkshire Clinical Commissioning Group. All alerts were reviewed and delegated to the appropriate clinicians. A log of safety alerts was monitored, reviewed and updated accordingly to ensure actions had been completed. We saw examples of recent alerts and we saw actions taken on alerts relevant to the practice.

Effective Rating: Requires Improvement

The practice was previously rated as Requires Improvement for providing effective services because of issues relating to staff training. Although we saw significant improvement to the concerns raised around staff training, we continue to rate the practice as Requires Improvement for providing effective services as well as two out of six population groups because:

- The practice had high exception reporting rates in relation to its Quality and Outcome Framework data which were higher than local and national averages. The practice's monitoring of exception reporting had not identified these as areas to review.

Effective needs assessment, care and treatment

Patients' needs were always assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes

Explanation of any answers and additional evidence:

The practice used a system through West Berkshire Clinical Commissioning Group for clinical guidance and agreed care pathways within the locality. This system allowed the practice to make effective referrals to other services, for example to physiotherapy and talking therapies.

Clinicians had access to best practice guidelines online and demonstrated they were providing care and treatment in line with these through clinical audits.

The practice had a system in place to monitor performance to improve outcomes for patients. However, there was limited monitoring of the outcomes in relation to exception reporting rates which meant that a number of patient's clinical needs had not been fully assessed.

Prescribing	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) (01/07/2018 to 30/06/2019) (NHSBSA)	0.69	0.56	0.75	No statistical variation

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured six monthly and annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Requires improvement

Findings

This population group was rated requires improvement due to higher than average exception reporting which the practice had not identified as part of its own monitoring. However, there were examples of good practice seen, such as:

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately and the practice have recently ordered an atrial fibrillation detection device for the waiting room.

Diabetes Indicators	Practice	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 (01/04/2018 to 31/03/2019) (QOF)	88.6%	78.5%	79.3%	Tending towards variation (positive)
Exception rate (number of exceptions).	17.6% (64)	12.1%	12.8%	N/A
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 (01/04/2018 to 31/03/2019) (QOF)	85.1%	78.9%	78.1%	No statistical variation
Exception rate (number of exceptions).	7.7% (28)	8.7%	9.4%	N/A

	Practice	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 (01/04/2018 to 31/03/2019) (QOF)	85.1%	81.4%	81.3%	No statistical variation
Exception rate (number of exceptions).	12.9% (47)	12.4%	12.7%	N/A

Other long-term conditions	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 (01/04/2018 to 31/03/2019) (QOF)	78.9%	74.6%	75.9%	No statistical variation
Exception rate (number of exceptions).	2.2% (9)	5.4%	7.4%	N/A
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 (01/04/2018 to 31/03/2019) (QOF)	92.4%	89.4%	89.6%	No statistical variation
Exception rate (number of exceptions).	17.1% (19)	10.7%	11.2%	N/A

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 (01/04/2018 to 31/03/2019) (QOF)	82.2%	81.8%	83.0%	No statistical variation
Exception rate (number of exceptions).	4.6% (51)	3.2%	4.0%	N/A
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 (01/04/2018 to 31/03/2019) (QOF)	93.2%	93.4%	91.1%	No statistical variation
Exception rate (number of exceptions).	4.3% (6)	5.9%	5.9%	N/A

Any additional evidence or comments

Data from the Quality and Outcome Framework indicators for 2018/2019 showed the practice had high exception reporting in a number of areas. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). For example:

The practice's overall exception reporting rate for cancer in 2018/19 was 31.3%. This was higher than both the local clinical commissioning group (CCG) average of 22.4% and the national average of 26.3%. However, the 2018/19 data demonstrated an improvement from the practice's 2017/18 data which showed exception reporting for cancer was 46.2%.

The practice's overall exception reporting rate for cardiovascular disease (CVD) in 2018/19 was 66.7%. This was higher than both the local CCG average of 25.9% and the national average of 25.6%. The 2018/19 data demonstrated a significant increase since 2017/18 data which showed exception reporting for CVD was previously 33.3%.

Exception reporting for Chronic Obstructive Pulmonary Disease (COPD) reviews had shown improvement since the last inspection which previously showed 33%. However, this still remained above local and national averages.

The exception reporting figures were highlighted to the practice during the inspection. The practice acknowledged that exception reporting was an area that improvements could be made in, but its monitoring systems had not identified these as areas to review. In addition, the practice was unable to provide any reasoning for these areas of high exception reporting. The practice provided unverified data to evidence its current exception reporting rates which were seen to be lower, but it acknowledged that exception reporting is typically done nearer the end of the year and so this figure was not wholly reliable.

We found that the practice had implemented a process to monitor and contact patients requiring a review or recall. For example, the practice used a system through Electronic Checking Leading to Improved Prescribing Safety and Efficiency (ECLIPSE) which highlighted when patients with diabetes required reviews. We also noted that patients received an initial contact for review or recall in the month of their birthday. We could see that the practice had a clear procedure, which it applied, however, the high exception rates did mean that a number of patients may not be receiving timely intervention or review.

Families, children and young people Population group rating: Good

Findings

- The practice has met the minimum 90% target for one of four childhood immunisation uptake indicators and the practice has met the WHO based national target of 95% for two of four childhood immunisation uptake indicators. However, the practice has not met the minimum 90% target for one of four childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Antenatal care was provided by weekly midwife clinics held at the practice.
- Young people could access services for sexual health and contraception. Details were also included on the practice website.
- The practice accommodated mothers who wished to breastfeed on site.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	66	77	85.7%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	63	67	94.0%	Met 90% minimum
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) (01/04/2018 to 31/03/2019) (NHS England)	64	67	95.5%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	64	67	95.5%	Met 95% WHO based target

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices

Any additional evidence or comments

The 2018/19 data from NHS England demonstrated an improvement in all childhood immunisations for children aged 2, compared to the previous inspection in September 2018. However, 2018/19 data demonstrated a decline in childhood immunisations for children aged 1 since the previous inspection.

We discussed this with the practice who told us:

- they continued to monitor data to help to improve figures;
- they continued to work with the Child Health Information Service (CHIS);
- they had arranged a meeting with the clinical immunisation lead to review the monthly performance database and look at further initiatives;
- they had introduced a new registration form to allow for a more user-friendly way to obtain a child's immunisation history;
- they were providing educational information to parents about the uptake of immunisations; and
- they had recruited another practice nurse, who was trained in immunisations, to start employment in November 2019, thereby increasing the number of appointments of childhood immunisations to be available.

Following the inspection, the practice provided unverified data to demonstrate that between April 2019 and November 2019, 69% of children aged 1 had received immunisations and were working towards meeting the target by the end of the working year in March 2020.

Working age people (including those recently retired and students)

Population group rating: Good

Findings
• Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. • Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery. • Patients could access contraceptive services including coil and implant fitting and removal.

Cancer Indicators	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) (01/04/2017 to 31/03/2018) (Public Health England)	73.5%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	68.4%	72.1%	72.1%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	60.6%	57.5%	57.3%	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. (01/04/2017 to 31/03/2018) (PHE)	53.8%	73.9%	69.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	59.5%	54.1%	51.9%	No statistical variation

Any additional evidence or comments
We saw unverified data from the practice that indicated cervical screening had improved since March 2018. The unverified data taken on 31 October 2019 showed that cervical screening performance for the last three years and six months for those aged 25-49 years was 79.6% and cervical screening performance for the last five years and six months for those aged 50-64 years was 83.2%. At the time of the inspection, the most recent 2018/19 verified data for cervical screening was not available to confirm the practice's current figures. To improve its uptake of cervical screening, the practice had taken the following actions: • A practice nurse had recently completed cytology training so two nurses were now qualified to carry out cervical screening. • The practice had recently recruited an experienced practice nurse who was due to start at the practice in November 2019. The practice told us this should help with further improving uptake by increasing the number of appointments available for cervical screening. • Additional practice nurse appointments were offered during extended opening hours on one Saturday every month. • Patients who had not responded to the cervical screening invitation were followed up with a phone call from the practice nurse and provided with information about cervical screening.

People whose circumstances make them vulnerable

Population group rating: Good

Findings
• Same day appointments and longer appointments were offered when required. • All patients with a learning disability were offered an annual health check. • End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. • The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule. • The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires improvement

Findings
This population group was rated requires improvement due to higher than average exception reporting which the practice had not identified as part of their monitoring. However, there were areas of good practice: • The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. • Same day and longer appointments were offered when required. • There was a system for following up patients who failed to attend for administration of long-term medication. • When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. • Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. • Patients with poor mental health, including dementia, were referred to appropriate services. Patients could self-refer to talking therapies, which ran weekly clinics at the practice.

Mental Health Indicators	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 (01/04/2018 to 31/03/2019) (QOF)	96.0%	90.9%	89.4%	No statistical variation
Exception rate (number of exceptions).	13.8% (4)	10.1%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	92.6%	91.6%	90.2%	No statistical variation
Exception rate (number of exceptions).	6.9% (2)	8.7%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	95.8%	85.3%	83.6%	Variation (positive)
Exception rate (number of exceptions).	6.5% (5)	5.9%	6.7%	N/A

Any additional evidence or comments
At the time of the inspection, the most recent 2018/19 verified data for exception reporting for patients with schizophrenia, bipolar affective disorder and other psychoses as well as patients diagnosed with dementia had demonstrated an improvement since the inspection in September 2018. However, the most recent 2018/19 verified data for exception reporting for depression was 48%, above Clinical Commissioning Group average (18.8%) and England averages (22.5%). This demonstrated a significant increase since 2017/18 data which showed exception reporting for depression was previously 25.9%. The practice acknowledged that exception reporting was an area that improvements could be made, but its monitoring systems had not identified these as areas to review. In addition, the practice was unable to provide any reasoning for these areas of high exception reporting. The practice provided unverified data to evidence its current exception reporting rates which were seen to be lower but it acknowledged that exception reporting is typically done nearer the end of the year, so the figures may not be accurate.

Monitoring care and treatment

The practice had undertaken a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. However, there was limited monitoring of the outcomes of care and treatment in relation to the practice's exception reporting rates.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	557.9	No Data	539.2
Overall QOF score (as a percentage of maximum)	99.8%	No Data	96.4%
Overall QOF exception reporting (all domains)	4.9%	No Data	No Data

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Partial
Quality improvement activity was targeted at the areas where there were concerns.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes
Explanation of any answers and additional Evidence: The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance to monitor outcomes for patients. In addition, the practice had recognised areas for review and improvement such as cervical screening. However, the practice's exception reporting was higher than local and national averages in a number of areas, including cancer, depression and cardiovascular disease. The practice had not identified these areas of high exception reporting and as a result had not targeted or recognised these as areas for improvement.	

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

The practice had carried out a two-cycled audit for antibiotic prescribing for acute rhinosinusitis (inflammation of the sinuses). The first cycle audit in January 2019 highlighted that only 14% of patients (two out of 14) who were prescribed antibiotics for acute rhinosinusitis were prescribed the correct antibiotic and correct dose or frequency. A repeat audit was carried out in April 2019 which demonstrated that 66% of patients (two out of three) who were prescribed antibiotics for acute rhinosinusitis were prescribed the correct antibiotic and correct dose or frequency. This demonstrated an improvement in providing appropriate antibiotic prescribing in line with The National Institute for Health and Care Excellence (NICE) guidelines.

The practice completed an audit in July 2019 for the use of treatment for patients with chronic kidney disease to ensure the correct dose of medication was used for all patients. An initial audit was carried out in June 2018 which did not identify any patients relevant to the audit. A second audit was carried out in July 2019 which identified six patients, and all were correctly managed. The practice therefore concluded that the medication was being safely prescribed.

A similar audit was carried out in September 2019 for the use of dabigatran (a blood thinning medicine) for patients over 75 years of age to ensure the correct dose was being used. An initial audit was carried out in June 2018 which identified six patients, four who were on the correct management and two had their dose reduced following review by their GP. A second audit was carried out in July 2019 and five patients were identified. Four out of the five were on the correct management and one had their dose reduced following review by their GP. The practice concluded that there had been an improvement in prescribing.

Effective staffing

The practice was able demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: The practice had recently introduced a new employee handbook and health and safety employee handbook which would be provided to all new employees on induction. These handbooks provided an appropriate overview of where employees could access policies and procedures relevant to their employment.	

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
Explanation of any answers and additional evidence: Staff were aware of local initiatives to improve patients' health and told us they actively signposted patients to appropriate services. In addition, the waiting area displayed various clinics and support services such as community groups, smoking cessation, exercise schemes and self-management information. The practice had recruited a social prescriber who was due to start employment in November 2019. Social prescribing is when health professionals refer patients to support in the community, in order to improve their health and wellbeing.	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	97.3%	94.4%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.6% (11)	0.6%	0.8%	N/A

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Policies for any online services offered were in line with national guidance.	Yes
Explanation of any answers and additional evidence: Staff we spoke to were clear on the requirement to obtain consent and provided clear examples to demonstrate their understanding of mental capacity. All staff had completed the Mental Capacity Act training.	

Caring Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

CQC comments cards	
Total comments cards received.	21
Number of CQC comments received which were positive about the service.	17
Number of comments cards received which were mixed about the service.	4
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comment Cards	21 comment cards were received, 17 of which contained positive comments while the remaining four contained mixed comments about the practice. Patients highlighted that they were pleased with the practice and the care provided. Staff were reported to be helpful, caring and responded to patient needs in a timely manner. Some patients also commented that they were happy with the access to appointments and Saturday clinic. However, some patients commented that they would like more choice of appointment times and would like quicker access to routine appointments.
Interviews with patients	We spoke with three patients on the day of inspection and all responded positively about the service at the practice. Patients described feeling happy with the availability of parking for patients, generally felt able to see the GP of their choice, and appointments usually ran to time. Patients felt appointments were easy to book and were satisfied with waiting up to two weeks for a routine appointment. Patients said they had enough time in appointments and felt involved in their care and treatment. Patients were aware of how to make a complaint and felt staff were always helpful and respectful.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
7407.0	257.0	121.0	47.1%	1.63%

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 (01/01/2019 to 31/03/2019)	89.0%	88.4%	88.9%	No statistical variation
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 (01/01/2019 to 31/03/2019)	88.8%	87.3%	87.4%	No statistical variation
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 (01/01/2019 to 31/03/2019)	93.9%	96.1%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	87.1%	83.9%	82.9%	No statistical variation

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

Any additional evidence or comments
The practice waiting area contained a comments and suggestions box to encourage patients to provide comments and suggestions on how to improve services at the practice. Reception staff also had access to a second comments box to record comments and feedback from patients. The practice had a clear 'You said, we are doing' noticeboard in the waiting area for patients to see how the practice were making improvements based on their feedback. Improvements included updating the practice telephone message, having more available staff to answer telephones during busy periods, engaging with local community services to offer patients personalised care plans to help to manage long-term conditions and working with neighbouring GP practices to offer a wider range of services (as part of the Primary Care Network).

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes

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 (01/01/2019 to 31/03/2019)	92.0%	93.4%	93.4%	No statistical variation

	Y/N/Partial
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 other languages and 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 161 patients who were also carers. This represented approximately 2% of the practice's patient population.
How the practice supported carers (including young carers).	The practice encouraged carers to let the practice know about their caring role, so they could be registered and be offered appropriate support. The waiting room had a carers noticeboard which provided information about carers support and the practice nurse was the carers champion at the practice to encourage identification and to be a key point of contact for carer information within the practice.
How the practice supported recently bereaved patients.	The practice told us that bereaved patients would receive a phone call from the GP to offer support and information leaflets were available in the waiting area.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Yes
Consultation and treatment room doors were closed during consultations.	Yes
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes
Explanation of any answers and additional evidence: All incoming calls to the practice were answered in the back-office area and reception staff spoke in quiet voices to patients at the reception desk.	

Responsive Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
Explanation of any answers and additional evidence: The practice had a cancellation line that patients could access to cancel any appointments that they no longer needed. Information regarding cancellations was available on the website and information was in the practice waiting area. The practice could signpost patients to a local service, called Caring in Hungerford, Action In Need (CHAIN), which supported patients with transport to and from the practice.	

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
• The practice had extended hours from 7am to 8am every Monday for pre-bookable appointments, until 7.30pm on alternate Thursdays and 8.30am to 11.30am on alternative Saturday mornings for pre-bookable appointments.	

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
7407.0	257.0	121.0	47.1%	1.63%

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 (01/01/2019 to 31/03/2019)	90.4%	95.3%	94.5%	No statistical variation

Older people — Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- The practice had a dedicated phone line for those on care plans to ensure patients were able to speak to a member of practice staff without delay.

People with long-term conditions — Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people — Population group rating: Good

Findings

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours on alternate Thursday evenings and alternate Saturday morning appointments.
- The practice had a user-friendly cancellation telephone line available as well as online booking for appointments and repeat prescriptions requests.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly. For example, the 'Time to Talk' group offered support for young people experiencing poor mental health and could be accessed at the practice on a weekly basis.
- The practice was an accredited dementia friendly practice and we saw evidence of dementia friendly signage being used throughout the practice.

Timely access to the service

People were able to access care and treatment in a timely way.

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Yes

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 (01/01/2019 to 31/03/2019)	89.0%	N/A	68.3%	Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	72.6%	69.5%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	64.2%	65.6%	64.7%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	68.8%	74.1%	73.6%	No statistical variation

Any additional evidence or comments
On the day of inspection, 31 October 2019, the next available routine appointment with a specific GP was on 6 November 2019 3pm. The next available Saturday appointment was available for that weekend. Patients we spoke with on the day of inspection told us they were satisfied with the appointment system, they found it easy to use and could book appointments when they required.

Source	Feedback
The NHS website	Since the last inspection in September 2018, the practice had received five new reviews and the practice had responded to all five. Ratings included one five star review, two four star reviews and two one star reviews. Positive comments referred to helpful staff who were understanding and polite, and the practice had an effective SMS service. However, other reviews referred to prescriptions that were late, and that the practice did not respond to a complaint.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care

Complaints	
Number of complaints received in the last year.	17
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

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes

Explanation of any answers and additional evidence:

Information regarding how to make a complaint was easily accessible in the practice waiting area and patients we spoke with were aware of how to make a complaint.

We reviewed a selection of recorded complaints and minutes from practice meetings and found that complaints were being discussed in a timely way and learning from complaints was being shared with staff.

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient arrived late and doctor declined to see them.	Apology emailed to the patient, discussed at full team meeting. Agreed that each event should be risk assessed by the attending clinician and appropriate action taken should be communicated to the patient.
Prescribing error and poor communication internally with patient.	Investigated by doctor and practice nurse. Patient offered explanation meeting. Doctor telephoned the patient to further discuss complaint and patient satisfied with response. Discussed at full team meeting. Learning points for practice nurse for diabetic prescribing and for wider team regarding communication.

Well-led Rating: Good

The practice was previously rated as Requires Improvement for providing well-led services because:

- There was a lack of oversight in the monitoring of staff training;
- Policies were in place but fully embedded or consistently used;
- The practice did not seek assurances that locum GP had appropriate checks and training carried out prior to then working at the practice;
- Risk assessments were either not undertaken or had not been acted upon in a timely manner;
- Staff role and responsibilities were unclear; and
- Staff did not always feel their concerns or issues raised would be appropriately addressed.

At this inspection, we rated the practice as Good for providing Well-led services because:

- The practice now had clear oversight in the monitoring of staff training.
- Practice policies were fully embedded, and the practice had a process to ensure policies were appropriately reviewed.
- The practice sought assurances that locum GPs had appropriate checks and training had been completed out prior to working at the practice.
- Appropriate risk assessments had been carried out and acted upon in a timely manner.
- Staff feedback had improved and staff now felt their concerns and suggestions were being appropriately addressed.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes

Explanation of any answers and additional evidence:

Since the previous inspection, the practice reviewed and updated their systems and processes to ensure compliance with practice policies and national guidance and introduced a new schedule for audits. In addition, the practice had introduced Bluestream, an online training software, which also allowed a clear oversight of training required to be completed and this was monitored on a regular basis.

Staff feedback was positive about the management team and staff we spoke to on the day of inspection reported an open door policy.

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: The practice provided evidence of its vision and values in its Statement of Purpose and in its presentation to us. The aims were to provide modern medicine in a traditional setting, to work in partnership with patients to provide the best quality health care in a safe and supportive environment.	

Culture

The practice had a culture which drove high quality sustainable care

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes

Explanation of any answers and additional evidence:

Staff we spoke to told us they felt able to raise concerns to the leadership team and they felt confident issues would be addressed.

We saw evidence of where the practice had carried out duty of candour in an appropriate and timely manner. For example, a patient's information was sent to the wrong patient in error, both patients were contacted, informed and apologised to.

The practice recently introduced an employee assistance programme and confidential helpline to offer additional support to staff.

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

Source	Feedback
Staff interviews	Feedback from staff we spoke to was positive and told us the practice was a good place to work and staff retention demonstrated this. Staff told us they felt supported and listened to. Staff said managers were friendly and approachable. All staff told us they were happy with the practice team as a whole and felt they all worked well together.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes

Explanation of any answers and additional evidence:
Policies were reviewed regularly and were available on the practices shared drive for easy access and a hard copy was maintained.

Since the last inspection in September 2018, the practice introduced a new management structure and developed clear guidance on the roles and responsibilities of each staff member. This led to a new assistant practice manager role being introduced. This was shared with all staff, both clinical and non-clinical, and was reviewed by management when roles and responsibilities change. Staff we spoke with on the day were clear about their own roles within the practice as well as the roles and responsibilities of other staff members.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes

Explanation of any answers and additional evidence:
Clinical audits had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.

Appropriate risk assessments were undertaken, and action was carried out in a timely way when risks were identified.

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making. However, the practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence: The practice was able to demonstrate monitoring of Quality and Outcome Framework indicator performance was appropriate and had taken steps to improve areas which had lower performance previously. However, higher than average exception reporting was highlighted in a number of areas and the practice could not provide assurance this was being monitored accurately as it told us its monitoring had not identified these as areas for review. The practice did not provide an explanation for these areas of high exception rates.	

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Any unusual access was identified and followed up.	Yes
Explanation of any answers and additional evidence: The practice's new website was launched in March 2019. The website was regularly monitored, and data was used to encourage and improve patient use. Administrative staff completed in-house training led by the assistant practice manager to ensure understanding of the online dashboard. The practice told us that online booking usage was currently at 30% and patients were being encouraged to use online services to reduce telephone calls in to the practice thereby improving access for those patients who could not action their requests online.	

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: Staff we spoke to told us they felt involved in the service improvement planning and felt their suggestions were listened to and addressed. For example, prior to the most recent fire risk assessment, one member of staff raised concerns about chairs being lined up in a corridor close to a fire exit and the practice moved these to a more appropriate location, keeping the fire exit clear.	

Feedback from Patient Participation Group.

Feedback
We spoke to a member of the Patient Participation Group (PPG) who confirmed the practice held regular meetings with them, and these were usually held every two months. The PPG felt valued and listened to by the practice and said the practice was open and honest about their challenges and actively encouraged feedback to help them to improve. The PPG told us the practice had improved the telephone message as a result of patient feedback and the PPG was working closely with the practice to improve signposting for patients. The PPG felt the complaints process was clear to patients and said information on how to complain was accessible to patients.

Continuous improvement and innovation

There were evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes

Explanation of any answers and additional evidence:

The practice is currently working within their Primary Care Network (PCN) to improve and increase services to the local population. The practice now has a clinical pharmacist, a social prescriber starting in November 2019 and there are discussions within the PCN to look at employing paramedics and physician associates.

The practice told us about their future plans to run a digital pilot programme for enhanced care home support at the local nursing home and plans to make the practice a training practice again once they are fully staffed.

A variety of regular formal and informal meetings were held at the practice to ensure all staff would be able to have discussions and share suggestions for improvements.

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 practices 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 no statistical variation, 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 no statistical variation 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 Bands	Z-score threshold
Significant variation (positive)	≤-3
Variation (positive)	>-3 and ≤-2
Tending towards variation (positive)	>-2 and ≤-1.5
No statistical variation	<1.5 and >-1.5
Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

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. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.

- 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 uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

- 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). This indicator does not have a CCG average and is scored against the national target of 80%.

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:
https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease
- **PHE**: Public Health England
- **QOF**: Quality and Outcomes Framework
- **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.