

Care Quality Commission

Inspection Evidence Table

Hungerford Surgery (1-537624945)

Inspection date: 7 October 2022

Date of data download: 8 September 2022

Overall rating: Good

Effective

Rating: Good

At our previous comprehensive inspection in October 2019, the practice was rated Good overall whilst rated Requires Improvement for providing effective services. The reason for this rating was:

- 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. 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.

During this desk-based review, we reviewed information provided by the practice and found improvements had been made to the monitoring of outcomes for patients with long term conditions and patients experiencing poor mental health. The practice has therefore now been rated as Good for providing effective services.

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

Effective needs assessment, care and treatment

Improvements had been made and patients' needs were 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
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Explanation of any answers and additional evidence: At the previous inspection, we found 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. During this desk-based review, the provider submitted evidence and data which showed the practice had reviewed the areas of limited monitoring and made improvements to ensure patients with long-term conditions and mental health diagnoses were appropriately recalled and clinical needs were assessed.	

Effective care for the practice population

Findings
<p>At the previous inspection, we rated the population group 'people experiencing poor mental health' as requires improvement due to higher than average exception reporting which the practice had not identified as part of its own monitoring.</p> <p>During this desk-based review, we reviewed information sent by the practice as well as quality outcomes framework (QOF) data from 2020. QOF requirements were modified by NHS England for 2020/21 to recognise the need to prioritise aspects of care which were not directly related to COVID-19. This meant QOF payments were calculated different and for inspections after October 2021, QOF indicators would no longer be included in reports.</p> <p>From our review of QOF data in 2020/21, we found improvements had been made and the monitoring of all areas relating to mental health were in line with local and national averages, with no areas of highlighted concern regarding exception reporting (in 2020, known to be personalised care adjustments).</p> <p>During this desk-based review, we reviewed information sent by the practice, including their current 2022 outcome data and found:</p> <ul style="list-style-type: none">• The practice had reviewed and updated their serious mental illness (SMI) protocol and appointed a member of the administration team to manage recalls of patients using a staggered approach throughout the year.• For physical health reviews of patients with SMI and patients diagnosed with learning disabilities, patients were seen initially by a practice nurse and then followed up by their named GP for a medication review. The practice provided information which showed by the end of June 2022, they had completed 53% of the annual SMI reviews due for 2022/23, which was above the 50% target.• Patients diagnosed with dementia had a review in the last 12 months was 60.5% which had met the minimum percentage of 35% so far for the year.

- The practice had also met the minimum percentage (50%) for a number of indicators for patients on the mental health register, this included the recording of blood pressure, body mass index, alcohol consumption and blood glucose levels.
- The practice had provided data which showed they were currently below target at 30% for the year 2022/23 for the percentage of patients aged 18 or over with a new diagnosis of depression who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis. However, the practice continued to make efforts to complete these reviews and had until 31 March 2023 in which to meet the target parameters of 45% - 80%.

In addition, the practice told us:

- There was a GP lead for mental health who provided oversight to the care provided and mentored the in-house mental health practitioner (MHP) and the trainee psychotherapist.
- The practice employed an MHP in December 2021 and they were the first point of contact for patients with mental health concerns. The MHP was able to assess and triage patients as well as refer them to secondary care for additional follow up.
- The MHP was closely supported by a trainee psychotherapist who attended the practice for up to four hours per week to support patients.
- Patients could also be signposted to the social prescriber who could support patients to improve their mental health and wellbeing by referring them to local services.
- In May 2022, the MHP and social prescriber held a patient group evening with a mental health charity to provide more information on how and where patients can access support for their mental health.
- A time to talk counsellor attended the practice on a weekly basis to provide support to young people with poor mental health.
- The practice also introduced a clear flowchart to support reception staff to direct patients with poor mental health to the most appropriate practitioner. This included how to support patients who were presenting in crisis.

Management of people with long term conditions

Findings

At the previous inspection, we rated the population group 'people with long term conditions' as requires improvement due to higher than average exception reporting (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) which the practice had not identified as part of its own monitoring, specifically those patients with diabetes, chronic obstructive pulmonary disease (COPD), cancer and cardiovascular disease (CVD).

During this desk-based review, we reviewed information sent by the practice as well as quality outcomes framework (QOF) data from 2020.

From a review of QOF data in 2020/21, we found monitoring of all areas of long-term conditions were in line with local and national averages, with no areas of highlighted concern regarding exception reporting (in 2020, known to be personalised care adjustments). For example:

- At the previous inspection, we found that exception reporting for the percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months

was 17.1%. During a review of QOF data from 2020/21, this had improved and had reduced to 6.8%. This meant more patients had their condition monitored within the appropriate timeframe.

From a review of the information sent by the practice for the year 2022/23 thus far, we found:

Diabetes

- The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification in the last 12 months was 76%, above the minimum target of 50% for the year 2022/23.
- The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 58%, above the minimum target of 38% for the year 2022/23.
- The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last HbA1c (blood sugar levels) is 58 mmol/mol or less in the preceding 12 months was 58%, above the minimum target of 35% for the year 2022/23.
- The percentage of patients with diabetes, on the register, with moderate or severe frailty in whom the last HbA1c (blood sugar levels) is 75 mmol/mol or less in the preceding 12 months was 86%, above the minimum target of 52%.

Asthma

- 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 a validated asthma control questionnaire, a recording of the number of exacerbations, an assessment of inhaler technique and a written personalised action plan was 75%, and this had exceeded the maximum target of 70% for the year 2022/23.

COPD

- The percentage of patients with COPD on the register, who have had a review in the preceding 12 months, including a record of the number of exacerbations and an assessment of breathlessness using the Medical Research Council dyspnoea scale was 68% which had met the minimum target of 50% for the year 2022/23.

Cancer

- The percentage of patients with cancer, diagnosed within the preceding 24 months, who have a patient Cancer Care Review using a structured template recorded as occurring within 12 months of the date of diagnosis was 49%, which was just below the minimum target of 50% for the year 2022/23. However, the practice continued to make efforts to complete these reviews and had until 31 March 2023 in which to meet the target parameters of 50% - 90%.
- The practice told us a lead GP was appointed for overseeing cancer care and an administration manager was responsible for tracking the practice performance and to invite patients in for reviews.

In addition, the practice told us:

- The practice were running a long-term care plan review project since May 2022 which aimed to streamline processes, reduce the number of appointments, improve patient and staff satisfaction and improve patient health outcomes. Alongside this, a project group was introduced and included

a clinical lead GP, a nurse, an administrative lead and administrative support to maintain and action recall lists. This group would carry out monthly meetings to review progress and highlight any concerns. In addition, the practice utilised additional staff available through the practice and from within the Primary Care Network (PCN) to support patients with long-term conditions. For example, clinical pharmacists, social prescribers and additional healthcare assistants and phlebotomists.

- The new long-term condition care planning process was promoted to patients at a town council meeting and at a community organisation event, during a briefing meeting with the patient participation group in May 2022, in the practice newsletter and on the practice waiting room television.
- Members of the administration team had been supported by the practice to develop into roles such as health care assistants and phlebotomists to support with the long-term condition care planning processes.
- Spirometry had resumed since the pandemic, in line with guidance and, in 2021, the practice was supported by a senior specialist respiratory nurse who provided enhanced training at the practice for the respiratory nursing staff.

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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	52	56	92.9%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	65	67	97.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	63	67	94.0%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	64	67	95.5%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR)	77	80	96.3%	Met 95% WHO based target

(01/04/2020 to 31/03/2021) (NHS England and Improvement)				
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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

At the previous 2019 inspection, the data for childhood immunisations for children aged one was 85.7% which was below the national minimum 90% target.

At this inspection, data for childhood immunisations had improved in all areas and now meets the national target of 95% for three of five areas, and the 90% minimum target for the remaining two areas.

To further improve childhood immunisations uptake, the practice told us:

- The recall process was managed by the immunisations lead nurse and administrative lead for recall. They reviewed the weekly lists of children due for immunisations supplied by the child health information service. Parents and/or guardians for the children were then contacted to book an appointment.
- Non-attenders and non-responders were coded as such to ensure they were added to the lists for further attempts to contact.
- Progress of uptake of childhood immunisations was discussed at full staff and clinical meetings on a monthly basis.
- The practice encouraged uptake on social media, the waiting room screen and on the practice website.
- Appointments were also offered during extended hours to allow parents/guardians to bring children in outside of normal working or school hours.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	74.8%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	74.5%	70.9%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	69.7%	67.7%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	51.1%	51.8%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Any additional evidence or comments
<p>At the previous 2019 inspection, the data for uptake of cervical screening was 73.5%, which was below the national target of 80%.</p> <p>During this inspection, data showed some improvement to uptake had been made but this remained below the national target. However, the practice was able to provide unverified data from the practice's own QOF indicators, which showed that, for the year 2022/23 so far:</p> <ul style="list-style-type: none"> The proportion of women eligible for screening and aged 25-49 years at the end of period reported whose notes record that an adequate cervical screening test has been performed in the time threshold (3.5 years) was 76% for the year 2022/23. The proportion of women eligible for screening and aged 50-64 years at the end of period reported whose notes record that an adequate cervical screening test has been performed in the time threshold (5.5 years) was 81%, for the year 2022/23. <p>In addition, the practice told us that:</p> <ul style="list-style-type: none"> Following the previous inspection, a lead nurse had been appointed to recall patients and to follow up those who did not respond. In 2020, the practice also took part in the cancer community enhanced service quality improvement scheme. The scheme aimed to carry out a three-month audit for all new cancers diagnosed, to determine whether patients could have been referred earlier and to identify if there were any missed screening opportunities. Whilst there were no earlier opportunities for diagnosis identified, the practice found that 22% of new diagnoses were identified by screening programmes and the

overall action was to continue to improve screening uptake for bowel, cervical and breast screening.

- Monthly recall lists were run and patients contacted by telephone, text message, email and letters to encourage uptake.
- The practice website provided information on cervical screening.
- Staff encouraged booking appointments on an opportunistic basis when they saw or spoke with patients. Reminders were added and highlight on patient records to ensure it was visible to all staff.
- For patients with learning disabilities who were due to attend for screening, they would be offered an appointment to attend the practice in advance of the screening to discuss the process with a nurse and to be provided with any aides to support patients to understand what to expect.
- Additional appointments were offered during extended hours and the practice told us they planned to run a dedicated cervical screening clinic during their extended hours in the upcoming months to improve their accessibility for patients who are not able to attend during core opening hours.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as 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.
- **UKHSA:** UK Health and Security Agency.
- **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.
- ‰ = per thousand.