

Care Quality Commission

Inspection Evidence Table

St Clements Partnership (1-543611756)

Inspection date: 24 January 2019

Date of data download: 21 January 2019

Overall rating: Good

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

Safe

Rating: Requires Improvement

The practice was rated as requires improvement for providing safe services because:

- Oversight of staff training was not fully established. We saw evidence to demonstrate that this was being addressed but no evidence which suggested the practice had assured themselves that staff were using appropriate systems and processes until training had been embedded.
- Governance systems and processes were under review due to a change in practice management and not had the opportunity to be fully embedded. For example, the monitoring of professional registrations.
- Actions identified in previous risk assessments to ensure the safety of patients and staff had not been actioned, for example, identified actions from the previous legionella risk assessment. However, we saw evidence which demonstrated the practice had already made arrangements to have new risk assessments completed.
- Learning from significant events had not been consistently documented and disseminated to relevant staff since November 2018.

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse but evidence of staff training was not consistent.

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.	Yes
Policies took account of patients accessing any online services.	Yes

Safeguarding	Y/N/Partial
Policies and procedures were monitored, reviewed and updated.	Yes
Policies were accessible to all staff.	Yes
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Partial
There was active and appropriate engagement in local safeguarding processes.	Yes
There were systems to identify vulnerable patients on record.	Yes
There was a risk register of specific patients.	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
<p>Explanation of any answers and additional evidence:</p> <p>During inspection, the practice told us it was aware that staff training was not up to date and full oversight was not in place yet. The new practice manager, who had joined the practice six months previously, was in the process of devising a new training record. We were told the practice had also recently transferred to a new online training provider. We asked the practice to send us its current record of staff training which we reviewed post-inspection. On review we found:</p> <ul style="list-style-type: none"> No training records for three GPs, one nurse practitioner and one practice nurse working at the practice. On request, the practice has since provided evidence for two GPs and the nurse practitioner to demonstrate they had completed the appropriate safeguarding training modules. The evidence showed these clinicians had completed the training prior to the practice's change of training provider. Of the remaining 10 GPs, seven had a record of completing training modules in both safeguarding adults and children that were relevant to their role. A further two GPs had a record of completing safeguarding adults training appropriate to their role but no record of safeguarding children training was documented. One GP had no record of completing safeguarding adults and children training. Of the remaining nursing team, including healthcare assistants, two nurses had no record of safeguarding adult or children training. Two healthcare assistants had a record of completing both modules, and one nurse and one healthcare assistant had a record of completing safeguarding adults training. Of the non-clinical staff, five had a record of completing both safeguarding adults and children training modules. A further seven had a record of completing safeguarding adults training. Of the 12 non-clinical staff members with one or two completed training records, four completed the training after the inspection date. The remaining 10 members of non-clinical staff had no record of completing any safeguarding training. <p>Staff we spoke to on the day of inspection demonstrated full understanding of safeguarding adults and children. We saw no evidence of harm because of the training inconsistencies as described. The practice told us during the inspection staff training was a priority and they have since set a deadline of the end of February 2019 for all staff training to be up to date and correctly recorded.</p>	

Safeguarding	Y/N/Partial
<p>The practice told us all the clinical staff had received a Disclosure and Barring Service (DBS) check. The practice was in the process of applying for further DBS checks for six non-clinical staff members to support with chaperone duties. We were told these would be place by 31 March 2019 and those staff members identified for chaperone duties were not doing so until the DBS checks had been confirmed.</p>	

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 and if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Partial
Staff had any necessary medical indemnity insurance.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>During the inspection, the practice reported that the professional registration status of one of its clinical members of staff had expired. This had only been discovered the previous day and was reported to have occurred in September 2018. The affected member of staff had been restricted to non-clinical duties until their registration had been reinstated. The practice confirmed they would be reporting this incident as a significant event and would be informing the appropriate professional bodies of this incident. We were given evidence of a completed significant event reporting form and the practice confirmed it had notified its medical indemnity insurance provider.</p> <p>Since inspection, the practice has also sent a copy of all its clinical staff members' professional registration renewal dates. The practice confirmed it would be monitoring the dates and sending renewal reminders to its clinical staff to ensure this incident was not repeated.</p> <p>We saw a copy of the practice's group medical indemnity insurance certificate which was dated 23 October 2018.</p>	

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: April 2018	Yes
There was a record of equipment calibration. Date of last calibration: November 2018	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: June 2018	Yes
There was a log of fire drills.	Yes

Date of last drill: 23 January 2019	
There was a record of fire alarm checks. Date of last check: Weekly	Yes
There was a record of fire training for staff. Date of last training: Ongoing online modules	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 30 November 2018	Yes
Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Fire safety training was recorded to have been completed by 34 members of staff within the previous six months. This was out of a reported total of 36 employed staff and 10 partners at the practice. The practice told us during the inspection that staff training was a priority and they have since set a deadline of the end of February 2019 for all staff training to be up to date and correctly recorded.</p> <p>The practice told us it was working through an identified action plan created from its recent fire risk assessment, which was received in December 2018. We saw the action plan had 17 actions for the practice to address, including contacting external utility companies for estimates of costs for specific work. Of those 17, two had been completed, 13 had actions documented in order to be completed, and the final two had not yet addressed. All actions had been identified to be completed as soon as is reasonably practicable.</p> <p>We saw evidence of the practice' emergency lighting having been tested in November 2018. This had indicated three lights needed replacing. The practice told us this had been done.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: Not available	No
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Ongoing	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice confirmed it had arranged for an external health and safety company to visit the practice and undertake a review to complete a full premises health and safety risk assessment. We saw this had been booked for 1 February 2019.</p> <p>We saw the practice's previous legionella risk assessment, completed in 2015. The practice confirmed no work on the building had been completed to date as the practice was awaiting its relocation to new premises. The practice told us annual water sample testing was being carried out and the last sample for testing had been sent in October 2018. We did not see evidence of the results of this water test.</p> <p>The practice confirmed weekly water temperature testing had been implemented prior to our inspection but we did not see evidence of any documentation to confirm this.</p> <p>We saw evidence of the practice completing health and safety at work risk assessments for staff members who were pregnant.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met but systems were not yet fully embedded.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Partial
Date of last infection prevention and control audit: November 2018	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence:	
We reviewed the practice's infection prevention and control (IP&C) policy during inspection. It included details about staff training, and the management of sharps and clinical waste. It also included information on how to manage infectious diseases, and informing public health offices of notifiable diseases. The IP&C identified the practice's new IP&C lead, who had taken over the role since November 2018. Further IP&C training was being sought through the local clinical commissioning group (CCG) to support them in their lead role.	
The training details provided by the practice showed 22 members of staff had completed IP&C training within the previous six months. One more staff member had completed the training after the inspection date. A further 15 had no record of IP&C training, and an additional two staff members had a record of out of date training. Another five staff members had not been included in the training information supplied by the practice.	
The practice had confirmed it was aware staff training was not up to date and that was a priority. The practice told us that a deadline of the end of February 2019 had been set for all staff training to be up to date and correctly recorded.	
We saw evidence of an IP&C audit completed by the CCG in November 2018. The practice provided evidence of a 54-point action plan that had been created from the IP&C audit and we saw evidence which demonstrated the practice was working towards completing the actions identified. For example, the practice had ensured all consultation rooms had single use aprons available, and clear signage about the correct use of sharps bins was evidenced in the treatment and consultation rooms.	

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
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	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
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Yes
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We saw evidence of signs promoting the National Early Warning Signs (NEWS) in all consulting and treatment rooms as well as the practice's corridors. (NEWS is a scoring system designed to support the quick assessment and response to acute or urgent illness). Staff told us the decision to put the NEWS signs in the corridors was to support clinicians in case an acutely ill patient was to collapse in the corridor.</p>	

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.	Yes
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
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
<p>Explanation of any answers and additional evidence:</p> <p>The practice told us all referrals were completed with the patient and then passed to the practice's administrative team to submit and monitor.</p>	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation but the monitoring of high-risk medicines was not fully embedded.

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) (01/10/2017 to 30/09/2018) <small>NHS Business Service Authority - NHSBSA)</small>	0.80	0.88	0.94	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). (01/10/2017 to 30/09/2018) <small>(NHSBSA)</small>	12.4%	11.4%	8.7%	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).	Yes
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.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Partial
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

Medicines management	Y/N/Partial
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
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	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
<p>Explanation of any answers and additional evidence:</p> <p>The practice told us the clinical pharmacist performed three-monthly searches for patients receiving high-risk medicines to ensure appropriate monitoring was taking place. (High-risk medicines are those medicines that carry an increased risk of causing significant harm if used inappropriately).</p> <p>We reviewed sample care records of patients receiving high-risk medicines, such as methotrexate, warfarin and lithium. We found as follows:</p> <ul style="list-style-type: none"> • The records of five patients receiving methotrexate demonstrated appropriate monitoring. • The records of five patients receiving warfarin demonstrated appropriate monitoring. • The records of 10 patients receiving lithium demonstrated three patients were overdue their monitoring check. The records showed the practice had attempted to contact the patients appropriately but this did not mitigate the risk that the patients might face if their treatment was not monitored. <p>We were told the practice had been informed by the local clinical commissioning group that it was in line with local practices with regards to its prescribing practice of controlled drugs. (A controlled drug is a medicine whose use is regulated by law under the Misuse of Drugs Regulations 2001). We invited the practice to share specific data about its monitoring of controlled drugs and it provided evidence to show it was in the lower half for prescribing rates compared to other local practices. This evidence had been provided by the local CCG. However, we did not see any evidence which demonstrated the practice did its own monitoring in this area.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong. However, the discussion and review of previous significant events had not been consistent.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
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.	Partial

Number of events recorded in last 12 months:	28
Number of events that required action:	26
<p>Explanation of any answers and additional evidence:</p> <p>The evidence we received from the practice prior to our inspection showed gaps in relation to when significant events had been discussed and if any relevant learning had been identified. Significant events which occurred between April and October 2018 were documented to have been discussed appropriately. But there was no evidence of such discussions taking place for significant events dating from November 2018 to the present. The practice confirmed a meeting had been scheduled for 7 February 2019 to discuss all previously received significant events from 2018.</p>	

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

Event	Specific action taken
Relative was concerned about clinical advice being given by a receptionist, rather than a clinician.	The practice discussed this event at the GP partners' meeting the following month. Further training was given to reception staff on how to support patients when they contacted the practice.
Phlebotomy sample was not put into correct box for collection.	The practice did not provide details to confirm if this event had been discussed at the GP partners' meeting. However, the outcome from the event itself was that the affected patient was contacted, apologised to and rebooked for the collection of another sample. The practice also confirmed reception processes for sample collection would be examined.

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
<p>Explanation of any answers and additional evidence:</p> <p>The practice told us the clinical pharmacist was responsible for dealing with all safety alerts. We saw evidence of a folder which contained all previously received safety alerts that was appropriately maintained with all documented actions. The pharmacist was supported by the pharmacy technician and the practice's prescribing lead GP.</p> <p>We reviewed three safety alerts and found the practice had acted appropriately for all three alerts.</p>	

Effective

Rating: Good

Effective needs assessment, care and treatment

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
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.	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 were in place 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
Explanation of any answers and additional evidence: We saw evidence of the practice using National Institute for Health, Care and Excellence (NICE) and Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidance to support evidence-based practice.	

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) (01/10/2017 to 30/09/2018) <small>(NHSBSA)</small>	1.30	0.68	0.81	No statistical variation

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> The practice supported people living in nine local nursing or residential homes. Each GP was allocated a home and completed one to two weekly 'ward rounds' to identify any issues in a timely manner. 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. Staff had appropriate knowledge of treating older people including their psychological, mental and

communication needs.

- Health checks were offered to patients over 75 years of age.

People with long-term conditions

Population group rating: Good

Findings

- The practice's exception reporting for its asthma and chronic obstructive pulmonary disorder indicators was lower than the local and national averages. However, it was higher than averages for some diabetes indicators.
- The practice told us they had encountered difficulties with its diabetes care capacity following the retirement of their previous lead diabetes nurse. The practice instead had established a virtual clinic with its in-house clinical pharmacist, lead GP and its remaining diabetic nurse. The practice confirmed it had recently employed and was awaiting the imminent start date a new diabetic nurse prescriber.
- Patients with long-term conditions had 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. Following the retirement of its previous lead diabetes nurse, the practice was in the process of supporting its other practice nurses to be trained to undertake diabetic reviews.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- 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.

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 (01/04/2017 to 31/03/2018) (QOF)	85.9%	78.9%	78.8%	No statistical variation
Exception rate (number of exceptions).	31.8% (215)	15.7%	13.2%	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 (01/04/2017	81.9%	77.0%	77.7%	No statistical variation

to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	20.7% (140)	12.8%	9.8%	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 (01/04/2017 to 31/03/2018) (QOF)	82.4%	81.5%	80.1%	No statistical variation
Exception rate (number of exceptions).	18.6% (126)	16.0%	13.5%	N/A

Any additional evidence or comments

The practice provided unverified data on its current position with regards to the diabetes QOF indicators, this was from the day of inspection. The results were as follows:

- The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months was 67%. The target for the practice to achieve by the end of March 2019 was 83%.
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 67%. The target for the practice to achieve by the end of March 2019 was 78%
- 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 was 74%. The target for the practice to achieve by the end of March 2019 was 75%.
- The practice exception reporting for diabetes was 10%, the equivalent of 70 patients.

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 (01/04/2017 to 31/03/2018) (QOF)	74.1%	75.7%	76.0%	No statistical variation
Exception rate (number of exceptions).	2.3% (22)	11.5%	7.7%	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 (01/04/2017 to 31/03/2018) (QOF)	92.4%	90.0%	89.7%	No statistical variation

Exception rate (number of exceptions).	3.0% (7)	15.2%	11.5%	N/A
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Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	83.4%	81.7%	82.6%	No statistical variation
Exception rate (number of exceptions).	6.6% (140)	5.1%	4.2%	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 (01/04/2017 to 31/03/2018) (QOF)	86.8%	91.2%	90.0%	No statistical variation
Exception rate (number of exceptions).	6.9% (26)	6.2%	6.7%	N/A

Families, children and young people

Population group rating: Good

Findings

- Two of the childhood immunisation uptake rates were in line the World Health Organisation (WHO) targets. For the remaining two targets, the practice was slightly below the WHO recommended uptake rates of 90%.
- 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.
- 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.
- Young people could access services for sexual health and contraception.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	105	111	94.6%	Met 90% minimum (no variation)
The percentage of children aged 2 who	130	146	89.0%	Below 90%

have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)				minimum (variation negative)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)	132	146	90.4%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	131	146	89.7%	Below 90% minimum (variation negative)

Any additional evidence or comments

We spoke with the practice about its uptake of childhood immunisations. The practice confirmed they had taken the following steps to improve uptake rates:

- It had appointed one of its practice nurses to be the new lead nurse for immunisations.
- The practice nurses were contacting the families of children who had not attended on the day of their immunisation appointment and being offered new appointments.
- Families of those children not to have received their age-appropriate immunisation were prompted when attending the practice for different reasons using alerts on the patient's records.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- 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.

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	67.6%	76.1%	71.7%	No statistical variation

49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	72.2%	76.8%	70.0%	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)	57.4%	64.7%	54.5%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	71.0%	74.7%	70.3%	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)	51.7%	54.0%	51.9%	No statistical variation

Any additional evidence or comments

We spoke with the practice about its uptake of cervical screening. During the discussion, the practice confirmed they had taken the following steps to improve its uptake rates:

- There was a poster campaign in the practice's waiting areas promoting cervical screening. The practice had used the same colours as national campaigns. Patients who were eligible for cervical screening were encouraged to book an appointment when they attended or contacted the practice for a different reason. This was supported through the use of alerts on patients' records.
- The practice confirmed appointments for cervical screening were available Monday to Friday until 6.30pm. There were additional appointments available via the hub at Badger Farm until 8.30pm on weekdays and at weekends.

Since inspection, we invited the practice to provide a more up to date figure on its uptake rate for cervical screening by eligible patients. The practice provided data dated July 2018 which showed the practice had an uptake rate of 67% for those patients aged between 25-64 years.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- 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 held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- 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.
- The practice reviewed young patients at local residential homes.

People experiencing poor mental health (including people with dementia)

Population group rating: **Good**

Findings

- The practice's exception reporting for all mental health indicators was lower than the local and national averages.
- 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.
- 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.
- All staff had received dementia training in the last 12 months in line with the practice's dementia friendly accreditation status.

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 (01/04/2017 to 31/03/2018) (QOF)	91.5%	87.6%	89.5%	No statistical variation
Exception rate (number of exceptions).	10.0% (17)	13.0%	12.7%	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 (01/04/2017 to 31/03/2018) (QOF)	93.0%	88.2%	90.0%	No statistical variation
Exception rate (number of exceptions).	7.1% (12)	11.7%	10.5%	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 (01/04/2017 to 31/03/2018) (QOF)	89.2%	82.5%	83.0%	No statistical variation
Exception rate (number of exceptions).	2.4% (4)	6.6%	6.6%	N/A

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	559.0	538.3	537.5
Overall QOF exception reporting (all domains)	7.4%	5.4%	5.8%

	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.	Yes

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

- A two-cycle audit of patients over the age of 75 years and receiving Sulfonylurea was undertaken in June 2017 and August 2018 with a view to review treatment. (Sulfonylurea is a medicine used in the treatment of type 2 diabetes and promotes the release of insulin from the pancreas). The audit was intended to identify those patients at risk of experiencing hypoglycaemia due to continued use of Sulfonylurea. (Hypoglycaemia is low blood sugar levels). In June 2017, 20 patients were identified as receiving Sulfonylurea. Following a review four had their dose reduced, nine no longer required the medicine and seven patients had no change to their prescription. In August 2018, of the 13 patients who had their dose stopped or reduced, eight patients were still maintaining target blood sugar results.
- An audit of the practice's vasectomy clinic performance was undertaken between 1 May 2017 and 1 May 2018. In that period the practice performed 234 vasectomies. Of those 234, zero cases experienced any post-operative complications. When compared with the practice's data from 2016/17, this represented an improvement as four cases experienced complications in that time-period. However, the practice informed us that due to changes in the commissioned vasectomy service in the local area, patients were not required to return to the vasectomy clinic to report any issues. The practice told us this could lead to a misrepresentation of figures.
- An audit of the practice's minor op's clinic was undertaken between 1 July 2017 and 30 June 2018. During that time frame, 69 surgical procedures were completed, compared to the 78 procedures completed in 2016/17. The audit confirmed no complications were encountered. Through the associated histology tests, the practice had an approximately 99% accuracy in pre-surgical diagnosis.
- A two-cycle audit was conducted to review the risk of bleeding in patients aged over 75 years taking aspirin but who did not have a proton pump inhibitor (PPI). (PPIs are a group of medicines that can be used for the prevention and treatment of acid-related conditions such as stomach ulcers). The initial audit in July 2017 identified 183 patients at risk. These were reviewed to determine if the taking of aspirin was still appropriate and those deemed suitable for a PPI were contacted by letter. A repeat audit in January 2018 identified 136 patients on aspirin but no PPI cover.
- The practice performed an audit of all patients receiving Allopurinol in August 2018. (Allopurinol is a medicine commonly used in the treatment of gout). A possible side effect of taking Allopurinol is worsening kidney function. By performing this audit, the practice reviewed all 144 patients and

found seven patients that required a medicine review.

- The practice reviewed the contents of its emergency bag and equipment to ensure specific equipment could be found quickly. The practice found all equipment was available but not in a cohesive manner; for example, cannulation equipment, although in the correct bag, was not kept together. Three members of clinical staff were timed in getting equipment ready for a mock emergency scenario before and after the emergency bag had been reviewed and rearranged. The average time prior to the bag improvements was 105 seconds, whilst the average time of a clinician being ready for an emergency once the bag had been rearranged was 46 seconds. We saw evidence of the practice's emergency bag arrangements, and found items suitably grouped together, clearly labelled and easily accessible.
- We saw evidence of further improvement activities via a Pincer cycle audit, an antibiotic prescribing action plan, a workload audit of the practice's GPs, and a West Hampshire Integrated Shared Diabetes Outcome Measures (WISDOM) diabetes care audit. (Pincer is an audit tool that is used to perform searches through GP patient records to identify any patients who may be being prescribed medicines that are commonly associated with medicine errors).

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles but the completion of staff training and staff appraisals was not yet consistently embedded.

	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
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	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.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, and pharmacists.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice told us it was aware that not all staff appraisals had been completed. The practice confirmed no appraisals had been completed since December 2017-January 2018. However, the practice was in the process of creating a new schedule for all staff appraisals to be completed annually every February, starting from February 2019. We saw evidence that showed these appraisals had been scheduled accordingly. Since inspection, the practice has confirmed 13 appraisals have so far been completed.</p>	

The practice's training records for safeguarding, infection prevention and control and fire safety have already been documented. Further details of inconsistent staff training were as follows:

- Out of a total of 46 staff members, 14 had a record of completing Basic Life Support BLS training all within the previous six months prior to the inspection day. A further three staff members were recorded as completing the training after the inspection.
- The practice told us a face-to-face training event had been arranged to cover BLS and was booked for 31 January 2019. The practice has since provided evidence of the face to face training session which a further 25 members of staff attended.
- Out of a total of 46 staff members, 13 had a record of completing Information Governance training, all within the previous 12 months prior to the inspection.
- Out of a total 46 staff members, 11 had a record of completing Mental Capacity Act training, all within the previous six months prior to the inspection.
- We saw evidence of additional training modules covering health and safety, carer awareness, equality and diversity, deprivation of liberty safeguards, conflict resolution, hand hygiene, and moving and handling. However, these modules were not consistently recorded as being completed by all members of staff.

The practice told us during the inspection staff training was a priority and they have since set a deadline of the end of February 2019 for all staff training to be up to date and correctly recorded.

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 (01/04/2017 to 31/03/2018) (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
Explanation of any answers and additional evidence: The practice held monthly whiteboard meetings with the local multidisciplinary teams to discuss vulnerable patients. These meetings included the district nursing team, social services, the Older Persons Mental Health team and the palliative care team.	

Helping patients to live healthier lives

Staff were 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
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
<p>Explanation of any answers and additional evidence:</p> <p>The practice told us they could offer referrals for patients to the local fitness gym, to Slimming World classes, and other local voluntary groups and organisations for additional support.</p>	

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 (01/04/2017 to 31/03/2018) (QOF)	91.3%	94.3%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.1% (3)	0.7%	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

Caring

Rating: Good

Kindness, respect and compassion

Staff treated 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
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

CQC comments cards	
Total comments cards received.	9
Number of CQC comments received which were positive about the service.	6
Number of comments cards received which were mixed about the service.	1
Number of CQC comments received which were negative about the service.	1

Source	Feedback
CQC Comment cards	Patients who completed positive comment cards said that all staff at the practice were professional, friendly, kind, respectful. Patients reported they felt looked after. Cards which contained mixed or negative comments reported abrupt and uncaring attitudes from some nursing staff members or rude receptionists due to a possible language barrier.
Patient interviews	Patients we spoke to on the day of inspection stated all staff were kind and professional towards them.
NHS UK website	The practice was rated 4.5 out of 5 stars on the NHS UK website, based on nine reviews, dating back to February 2017. Of those 23 reviews, 22 of those ratings scored the practice 5 out of 5 stars for dignity and respect. Comments made by some patients stated staff were kind and professional. All areas of practice staff were described as supportive and efficient when speaking with patients. One out of the total nine reviews stated the practice had received a formal complaint about treatment received.

Any additional evidence
One comment card received during the inspection did not refer to the practice.
It was noted from the NHS UK website that the practice had not responded to any of the nine reviews left by patients.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
17,571	256	97	37.9%	0.55%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)	95.4%	91.8%	89.0%	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 (01/01/2018 to 31/03/2018)	96.8%	91.0%	87.4%	Variation (positive)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	100.0%	97.2%	95.6%	Significant Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	89.2%	87.6%	83.8%	No statistical variation

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

Any additional evidence
The practice provided us with evidence regarding patient satisfaction from its vasectomy clinic. The questionnaire was devised and analysed by Solent NHS Trust and the practice was provided with a summary. On review of the result, the practice scored above average in patient satisfaction and was the top scoring service overall in the local area. In total, the practice scored 3.82 out of a total of 4 in overall patient satisfaction.

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
<p>Explanation of any answers and additional evidence:</p> <p>Patients were directed to the appropriate waiting area via signs in the waiting room. These signs confirmed which floor each clinician was based on and where their appointment would be.</p> <p>The practice was recently accredited as a Dementia Friendly practice and was the first practice in Winchester to be awarded a Learning Disability friendly accreditation status in 2017.</p> <p>The practice told us they facilitated a monthly carer's clinic with the Princes Trust. Carers would be able to book an appointment via the practice and access advocacy services as required through the Princes Trust.</p>	

Source	Feedback
CQC Comment cards	<p>Patients who completed positive comment cards said staff were efficient and thorough in treating them. Patients felt cared for and had their concerns addressed appropriately. Patients felt reassured by the clinicians and valued the time clinicians took to make sure patients understood their treatment options.</p> <p>Cards which contained mixed or negative comments reported continued issues with prescriptions on a monthly basis.</p>
Interviews with patients.	Patients we spoke to on the day of inspection reported clinicians listened to their needs and preferences. Patients confirmed they understood the information that clinicians gave them and were given time to ask any questions they may have.
NHS UK website	The practice was rated 4.5 out of 5 stars for involvement in decisions and 5 out of 5 stars for providing accurate information. Comments made by some patients confirmed information provided by staff was easy to understand. Patients stated they did not feel rushed and could ask questions about treatment options as needed. One comment felt they had been let down by the clinicians at the practice and would be changing GP practices as a result.

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	100.0%	95.8%	93.5%	Significant Variation (positive)

Indicator	Practice	CCG average	England average	England comparison
their care and treatment (01/01/2018 to 31/03/2018)				

	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
<p>Explanation of any answers and additional evidence:</p> <p>We saw evidence of a hearing loop in use in the reception and waiting areas of the practice.</p> <p>We saw evidence of the practice's electronic sign-in system having the option of multiple languages to support patients when confirming their attendance for an appointment.</p> <p>Staff we spoke to during the inspection confirmed they actively used Big Word, Translate Line and Google Translate to support them during consultations with patients whose first language was not English.</p>	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 268 patients that were also carers. This represented approximately 1% of the practice patient's population.
How the practice supported carers.	The practice supported carers with an NHS health check and seasonal flu vaccine. The practice has worked with the Princes Trust to support carers by providing a space for a monthly carers clinic with a representative from the charity.
How the practice supported recently bereaved patients.	The practice told us the named GP contacted recently bereaved patients personally to offer support and information. On review of patients' records we saw evidence of appropriate support for carers during end of life care.

Privacy and dignity

The practice respected respect 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:

The practice told us they had recently rearranged the ground floor reception and waiting room area to further promote patient confidentiality. For example, the chairs for patients closest to the reception desk had been turned around and were now directed away from the reception desk.

Receptionists confirmed all incoming telephone calls to the practice were answered in the back office, away from the waiting area. We saw that receptionist staff using low voices when speaking with patients at the reception desk.

The practice had an electronic sign-in machine that allowed patients to confirm their attendance for an appointment without needing to speak with a receptionist.

Responsive

Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
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.	Partial
The practice made reasonable adjustments when patients found it hard to access services.	Yes
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Yes
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice told us it remained in the process of looking for new premises. This had been ongoing for many years and the practice was still unsure of when local planning permission would be agreed. Feedback we received from patients expressed they felt the practice building was looking tired but it remained clean.</p> <p>The current premises were a three-storey building. The upper floors were accessible via a lift but patients were informed via posters that the lift was only operational until 6pm each day. Staff we spoke to on the day confirmed consulting and treatment rooms would be rearranged to suit patients' needs if use of the lift was not an option.</p> <p>The practice was a site for a community vasectomy clinic which was facilitated by the GPs at the practice. Appointments were booked centrally through Southern Health NHS Trust and patients could request the site for the procedure to be undertaken.</p>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.00am-6.30pm
Tuesday	8.00am-6.30pm
Wednesday	8.00am-6.30pm
Thursday	8.00am-6.30pm
Friday	8.00am-6.30pm
Extended hours:	
Monday	7.30am-8.00am & 6.30pm-7.00pm
Tuesday	6.30pm-7.00pm
Wednesday	6.30pm-7.00pm
Thursday	7.30am-8.00am & 6.30pm-7.00pm
Saturdays (alternate)	9.00am-12.30pm

Any additional evidence or comments

Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available Monday to Friday 5.00pm until 8.30pm, Saturdays 8.00am to 4.00pm and Sundays 8am until 12noon.

Information about out of hours care was available on the practice's website.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
17,571	256	97	37.9%	0.55%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	100.0%	96.3%	94.8%	Significant Variation (positive)

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.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice told us it was working with its GP Federation service to further support its long-term condition reviews by accessing appointments for patients at weekends. This allowed patients greater flexibility with appointment choice.
- 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

- Practice nurse appointments were available until 6.30pm Mondays and Thursdays for school age children so that they could attend outside of school hours.
- The practice ran daily counselling sessions at Winchester College to support pupils. The practice told us the housemasters at the college could refer pupils directly to the counselling service which was facilitated onsite at the college by one of the practice's GPs.
- The practice ran a similar but smaller support service for the pupils at Pilgrims School in Winchester.
- 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.
- Parents with concerns regarding children under the age of 10 could attend a drop-in clinic held at the same time as the twice weekly baby clinic.

Working age people (including those recently retired and students)

Population group rating: **Good**

Findings

- The practice ran health and counselling clinics three times a week onsite at the University of Winchester campus for students to access. This was facilitated by some of the GPs at the practice. Students were still able to access the practice if preferred. The practice held termly 'at-risk' meetings with the university's mental health support team to discuss any students that were of a concern and in need for additional support.
- Since inspection, the practice has provided evidence of its most recent meeting with the University of Winchester's mental health support team, dated 7 February 2019. At this meeting, an update on the progress of six patients was discussed and plans of action were decided upon for both the practice and the support team to work from.
- 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.
- The practice was open until 7.00pm on a Monday and Friday. The practice was open on alternate Saturdays until 12.30pm. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available weekday evenings, and on Saturdays and Sundays.

People whose circumstances make them vulnerable

Population group rating: **Outstanding**

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless

people and those with a learning disability.

- The practice ran weekly bespoke health clinics at Trinity House, the Winchester-based homeless shelter. Two of those clinics were GP-led and a further two were nurse-led clinics. The clinics covered issues surround drug and alcohol use, sexual health, minor illnesses, dressings, health promotion and flu vaccines.
- This service was created in 2011 in response to an invitation from Mid Hants Primary Care Trust to provide services to the homeless in Winchester City. The practice has developed the service to its current four session a week programme. The practice provided data to show that in 2016-2017, it saw a total of 602 patients through these clinics at Trinity House. The total number of visits by these patients totalled 11,761 visits in the same time period.
- Outcomes for these patients following attendance at the clinics in Trinity House included improved engagement with therapy sessions and engagement with structured learning groups. Patients were finding more appropriate housing, and employment or volunteering placements. They were reducing substance misuse and engaging with related support programmes, and had improved personal outcomes such as increased confidence and self-esteem.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. This was reflected in the practice's Learning Disability friendly status since 2017.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice has developed working relationships with the local Adult Mental Health team as well as the Perinatal Psychiatry team to support patients accessing those services.
- 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.

Timely access to the service

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

National GP Survey results

	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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had created an Urgent Care team to treat patients for urgent, on the day health issues. This team was made up of a duty GP and two nurse practitioners. (A nurse practitioner is trained to assess patient needs, order and interpret diagnostic and laboratory tests, diagnose illness and disease, prescribe medication and formulate treatment plans).</p>	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	92.2%	N/A	70.3%	Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	66.7%	74.7%	68.6%	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 (01/01/2018 to 31/03/2018)	67.3%	68.6%	65.9%	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 (01/01/2018 to 31/03/2018)	70.4%	78.7%	74.4%	No statistical variation

Source	Feedback
CQC comment cards	<p>Patients who completed positive comment cards said appointments were easily accessible and patients could get an appointment as required.</p> <p>Cards which contained mixed or negative comments reported longer waiting times to see a GP. Other comments referred to an increased difficulty in getting hold of the practice on the telephone. Patients requested more online consultations due to their own difficulties in maintaining conversations over the telephone.</p>
Patient interviews	Patients we spoke to on the day of inspection confirmed appointments for urgent reasons were easily available. For a routine appointment, or to see a specific clinician, patients told us they were having to wait two to three weeks for an appointment.
NHS UK website	The practice was rated 4.5 out of 5 stars for telephone and 4 out of 5 stars for appointments. Comments made by some patients stated appointments were easy to access and urgent needs were addressed on the same day. One review contained a comment which referred to a recent increase in waiting time.

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.	42
Number of complaints we examined.	5
Number of complaints we examined that were satisfactorily handled in a timely way.	5
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

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient was unhappy with how reception staff had treated them.	The practice confirmed the patient had been contacted and apologised to. The complaint was discussed at a following reception meeting. The practice was in the process of sourcing additional customer care training for all receptionists and was considering creating a new position in the practice to address patient service experiences.
Patient was not comfortable with choice of GP.	The practice confirmed the patient had been contacted and apologised to. Additional correspondence between the practice and patient was reviewed during the inspection and demonstrated an agreement had been reached for the patient to have a different GP that suited their personal needs.

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels despite recent changes in practice leadership, and there was evidence to show that the practice was managing a period of transition well.

	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:	
The practice had experienced changes to its leadership structure in the last six months. The practice had a new registered manager, confirmed by the Care Quality Commission (CQC) on 22 January 2019. (A Registered Manager is an identified professional who is responsible for the carrying out of the regulated activities at a practice. A GP practice is required by their CQC registration to have a Registered Manager in post). A previous senior GP partner had retired in July 2018 but had not yet been removed from the practice's CQC partnership registration certificate.	
The practice had employed a new practice manager six months previously and a new deputy practice manager four months previously. Staff told us during inspection this change in practice management had led to significant improvements in the day to day experiences of staff. For example, staff reported practice management were more approachable than previously. The practice was described by staff as becoming more positive.	
The practice told us it had identified what issues were a priority, for example, staff training, the health and safety of staff and patients within the building and staff appraisals. We saw evidence of progress being made and deadlines having been set to address these issues.	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care but improvements needed more time to be completed and fully embedded.

	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
<p>Explanation of any answers and additional evidence:</p> <p>The practice told us it was aware it had shortfalls in its current situation, for example the practice's premises were no longer suitable for its use and oversight of governance arrangements had slipped. For example, staff training records were inconsistent and not up to date, some staff appraisals were overdue, and practice policies and the business continuity plan needed reviewing and updating. However, we saw evidence which demonstrated the practice was making improvements in the areas where it could and an action plan was in place for full compliance to be achieved.</p>	

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
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice told us clinicians were encouraged to attend a daily informal coffee meeting. This created an opportunity for clinicians to discuss cases as well as promoting well-being amongst staff.</p> <p>We saw evidence of the practice's commitment to the Duty of Candour in their responses to significant events and complaints. (Duty of Candour is a legal duty for GP practices to be open and honest with patients or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future).</p>	

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

Source	Feedback
Staff interviews	Staff we spoke to during the inspection said they felt supported by the practice and its new management team. They described managers as more approachable and felt the practice had an open-door policy. Staff said they were happy to work at the practice and enjoyed the challenges they encountered at the practice. They knew they could rely on their colleagues for advice and support as required.
Staff questionnaires	Staff described the practice as a busy and challenging environment to work in. However, due to the support they had from colleagues, GPs, nurses and managers, staff were happy with their working environment. Staff wanted to provide the best service they could to patients and enjoyed doing so. Staff described GPs, nurses and managers approachable and knew they could ask for help if it was needed.

Governance arrangements

There were responsibilities, roles and systems of accountability to support good governance and management. However, these were under review.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice's new management team was in the process of reviewing:</p> <ul style="list-style-type: none"> • training and appraisal process; • business continuity plan; • internal policies and procedures; • personnel records; • health and safety, security and fire risk assessments; <p>We saw evidence of appointments booked with external contractors to assess the practice.</p> <p>We saw evidence of the practice changing its appraisal programme and that dates had already been booked for all staff appraisals to now take place in February 2019.</p> <p>We saw evidence of the practice addressing its inconsistencies in the completion and recording of staff training. The practice confirmed an action plan to ensure all staff training was completed by the end of February 2019.</p>	

Managing risks, issues and performance

There were clear processes for managing risks, issues and performance but due to recent changes, these were not all fully embedded.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>We saw evidence of previous risk assessments being completed but minimal evidence of issues identified in those assessment having been addressed. The practice told us new risk assessments had already been scheduled to take place, for example a full health and safety risk assessment was to be undertaken on 1 February 2019.</p> <p>The practice told us it was in the process of completing all the actions identified in its most recent infection prevention and control audit. We saw evidence of newly introduced items throughout the</p>	

practice as a result of the IP&C audit. For example, disposable aprons in all consulting and treatment rooms.

The practice told us it was in the process of reviewing its business continuity plan. We saw a copy of the previous plan which was dated 2015.

New systems and processes that had been introduced, had not yet had sufficient time to be considered fully embedded. For example, the monitoring of staff professional registrations or the dissemination of learning from all significant events and complaints.

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making but not in relation to actions identified from previous risk assessments.

	Y/N/Partial
Staff used data to adjust and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence: The practice confirmed actions from previous risk assessments had not been fully completed. As a result, the practice had already arranged for new risk assessments to be carried out. We were shown evidence of an external contractor booked to visit the practice on 1 February 2019 to do this.	

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
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

Feedback from Patient Participation Group.

Feedback

We received feedback from three members of the practice's patient participation group (PPG).

We were told the practice building had long been a restriction to the practice but delays in the practice's relocation had been unavoidable due to external issues.

The PPG confirmed they had previously not always felt fully utilised by the practice, although they have been involved in patient surveys. However, following a recent meeting and the arrival of a new practice manager, the PPG were more optimistic and positive about being involved more with the practice in the future.

The PPG did not feel the complaints policy of the practice was as easily accessible as it could be for all patients, but felt this could be an area that they could support the practice with. However, they confirmed the practice was open and honest with them about previous complaints.
The PPG confirmed the practice met the needs of the various population groups appropriately.

Any additional evidence or comments

Staff reported that the practice had responded to patient feedback by:

- retaining an ear syringing service;
- rearranged the practice's waiting area to improve access for those patients with mobility issues.

Continuous improvement and innovation

There were 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

Examples of continuous learning and improvement

The practice was a well-established GP training practice. Four of the GP partners were certified GP trainers and supported GP Registrars when they were attached to the practice. At the time of the inspection, the practice had two GP Registrars attached to it.

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 Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	No statistical variation	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
6	No data	Null

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

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

- 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.

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>

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.