

Care Quality Commission

Inspection Evidence Table

University Medical Group (1-574198441)

Inspection date: 17 June 2019

Date of data download: 10 June 2019

Overall rating: Outstanding

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

Safe

Rating: Good

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Y
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
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.	Y
Explanation of any answers and additional evidence:	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> The practice chaperone procedure was clearly displayed, and only clinical staff undertook chaperone duties. Safeguarding policies were regularly reviewed and quick guides setting out local safeguarding team contact numbers were available in all clinical rooms. Staff we spoke with were clear on their responsibilities for safeguarding patients and knew who the practice leads were for both child and adult safeguarding. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff had any necessary medical indemnity insurance.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Our sampling of eight records of staff employed since the last inspection showed that all necessary pre-employment checks had been undertaken. The practice undertook risk assessments, which were recorded, for staff that did not have direct patient contact to determine whether a DBS check was required. 	

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: 20/12/2018 University Medical Centre and 19/12/2018 Whitley Villa	Y
There was a record of equipment calibration. Date of last calibration: 24/07/2018 both sites	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: Sept 2018 at University Medical Centre and June 2019 at Whitley Villa.	Y
There was a log of fire drills. Date of last drill: 17/08/18 at University Medical Centre and 25/04/19 at Whitley Villa.	Y

There was a record of fire alarm checks. Date of last check: Weekly fire alarm tests are carried out at both sites. There was a record of annual fire alarm servicing for both sites.	Y
There was a record of fire training for staff. Date of last training: Fire training undertaken annually by all staff using an online training programme.	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 12/12/18 University Medical Centre and 26/04/19 at Whitley Villa.	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> A member of the management team undertook a monthly visual checks of premises fire and electrical safety. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 10/06/19 at University Medical Centre and 06/06/19 at Whitley Villa. In addition, a monthly 'walk through' of the practice was undertaken to identify any premises risk and take action when risks were identified.	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 10/06/19 at University Medical Centre and 06/06/19 at Whitley Villa.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Area risk assessments were undertaken every month. There was evidence of risks being identified and action taken. For example, servicing of the emergency lighting had been booked. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Date of last infection prevention and control audit: July 2018	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Our visual inspection of both sites identified that both were kept clean and tidy. • The staff training records showed that staff had completed training on infection prevention and control relevant to their roles. 	

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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y

Explanation of any answers and additional evidence: Example of covering absence of a member of duty team.

- There were records of training undertaken about sepsis awareness.
- The records of patients at risk or with complex needs were highlighted to identify any additional care and support needs.
- There was an adult at risk register in addition to the children at risk register.
- Staff told us that there were enough staff on duty to provide a safe service for patients. Staff were aware that recruitment had either taken place or was underway to fill any vacancies. For example, a new practice nurse was due to commence duties in July 2019 and a new practice manager had been employed to commence in post the day after inspection.

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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a system in place to monitor referrals made for suspected cancer under the two weeks wait protocol. We discussed this with the practice for them to consider whether the system required an additional check added. 	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) <small>(NHS Business Service Authority - NHSBSA)</small>	0.50	0.78	0.88	Significant Variation (positive)
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). (01/04/2018 to 31/03/2019) <small>(NHSBSA)</small>	7.4%	9.1%	8.7%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2018 to 31/03/2019) <small>(NHSBSA)</small>	4.40	5.46	5.61	Variation (positive)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) <small>(NHSBSA)</small>	1.21	1.78	2.07	Tending towards variation (positive)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
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.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y

Medicines management	Y/N/Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
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.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were 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.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
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.	Partial
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Our check of medicines held in both secure cupboards and medicine fridges identified that there was a stock control and stock rotation system in place. All medicines we checked were in date. • The practice held medicines for use in an emergency. We discussed the range of medicines held for this purpose. The practice had completed risk assessments for emergency medicines which identified that some medicines were not held due to the proximity to an ambulance station that provided quick emergency response. Following our discussions, the practice commenced a review of their risk assessments. • Staff responsible for monitoring the temperatures of medicine fridges told us that they checked secondary temperature readings if the first reading was out of recommended temperature range. The practice policy required such a second check to be recorded. However, on six occasions in the last five weeks one fridge had a first temperature reading above recommended range. Staff told us they checked the secondary thermometer readings, and these showed the fridge in temperature range. The data logs of secondary thermometer readings confirmed this. Staff had omitted to follow practice policy to record the second check. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	54
Number of events that required action:	54
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The formal dissemination of learning from significant events was supported by sharing of learning via daily team 'huddles'. Significant events were recorded in detail. There were two logs of events one for clinical events and a second for non-clinical events. Staff were able to tell us about significant events that had taken place relevant to their roles and responsibilities. 	

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

Event	Specific action taken
Patient collected prescription had blood test form for another patient included with their prescription.	Staff reminded to check before handing out prescriptions and duty of candour discharged by contacting affected parties.
Nurse found out of date medicines in clinical rooms.	Immediate action to remove out of date medicines. Checked all emergency medicines to ensure all in place. Checking role handed to nurse administrator to undertake more frequent checks.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff we spoke with were aware of their responsibility to act on safety alerts relevant to their area of work. The practice had a system in place to record action taken in response to safety alerts. 	

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.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways were in place to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y

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) (01/04/2018 to 31/03/2019) <small>(NHSBSA)</small>	0.55	0.56	0.77	No statistical variation

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- 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

- 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.
- 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 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) <small>(QOF)</small>	72.5%	77.2%	78.8%	No statistical variation
Exception rate (number of exceptions).	13.4% (79)	12.2%	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 to 31/03/2018) <small>(QOF)</small>	83.1%	78.9%	77.7%	No statistical variation
Exception rate (number of exceptions).	12.7% (75)	8.6%	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) <small>(QOF)</small>	77.5%	78.6%	80.1%	No statistical variation
Exception rate (number of exceptions).	16.1% (95)	12.2%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) <small>(QOF)</small>	64.6%	75.7%	76.0%	Variation (negative)
Exception rate (number of exceptions).	2.3% (25)	5.2%	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) <small>(QOF)</small>	92.2%	90.5%	89.7%	No statistical variation
Exception rate (number of exceptions).	7.2% (11)	9.9%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	82.7%	82.0%	82.6%	No statistical variation
Exception rate (number of exceptions).	5.2% (76)	3.0%	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)	94.1%	93.3%	90.0%	No statistical variation
Exception rate (number of exceptions).	9.9% (13)	6.9%	6.7%	N/A

Any additional evidence or comments

- The practice focused on improving their performance in providing reviews of treatment for patients with long term conditions in 2018/19. Preliminary data, yet to be validated and published, showed improvement OF 6% in meeting QOF targets and a reduction in exception rates.
- Benchmarking information, for West Berkshire GP practices, from the local clinical commissioning group (CCG) for 2017/18 identified a 20% improvement in indicators for care of patients with diabetes. This improvement was achieved during a period when the number of patients diagnosed with diabetes had increased by 10%.
- The 6% improvement in QOF indicators included an improvement in undertaking reviews of care for patients diagnosed with asthma.

Families, children and young people

Population group rating: **Good**

Findings

- Childhood immunisation uptake rates were meeting contract targets.
- 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. There was also a system in place to follow up when children failed to attend an appointment at the practice.
- 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)	277	302	91.7%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	251	269	93.3%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)	252	269	93.7%	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)	251	269	93.3%	Met 90% minimum (no variation)

Any additional evidence or comments

- Nursing staff proactively followed up families that failed to attend for child immunisations. These families received a telephone call from a nurse to remind them of the benefits of immunisation and immediate re-booking of the appointment.

Working age people (including those recently retired and students)

Population group rating: **Good**

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. There was also a system in place to ensure students attending the local university received relevant immunisations if these had not been administered before they attended university and registered with the practice.
- 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 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	60.8%	71.9%	71.7%	Tending towards variation (negative)
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	69.0%	72.1%	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)	53.6%	57.5%	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)	80.8%	73.9%	70.2%	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)	60.0%	54.1%	51.9%	No statistical variation

Any additional evidence or comments

- The practice recognised that the uptake of cervical cancer and breast cancer screening was below average. The practice identified this as due to both students receiving screening at their home practice and patients from abroad returning to their home country for screening. A targeted campaign had been undertaken in 2018 and data held by the practice showed an increase in cervical cancer screening to 70% in the last year. The campaign to promote benefits of screening was ongoing. The local clinical commissioning group (CCG) had recognised issues in attaining the national cervical screening target of 80% and had set a local target of 70% for 2019/20.

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, travellers and those with a learning disability. We were given examples of the support given to homeless patients.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

- The practice undertook both medicine reviews and health checks at local residential homes for young patients diagnosed with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: **Good**

Findings

- 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.
- Systems were in place to identify patients who were assessed to be at risk of suicide or self-harm.
- 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.
- The practice demonstrated that they had a system to identify people who misused substances.

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)	96.4%	92.2%	89.5%	No statistical variation
Exception rate (number of exceptions).	12.5% (20)	12.6%	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)	67.1%	91.0%	90.0%	Variation (negative)
Exception rate (number of exceptions).	12.5% (20)	10.3%	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)	84.2%	84.4%	83.0%	No statistical variation
Exception rate (number of exceptions).	3.1% (3)	6.0%	6.6%	N/A

Any additional evidence or comments

- Data we saw which had yet to be externally verified, showed an improvement in the QOF indicators for care of patients diagnosed with long term mental health problems. The overall performance in these indicators had improved by over 6%. Due to the higher than average number of students registered at the practice many received care for their condition from the student mental health services. We saw documented evidence of the practice liaising closely with the student mental health team to coordinate the care of student patients registered with the practice.

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)	534.7	541.8	537.5
Overall QOF exception reporting (all domains)	6.0%	5.1%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y

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

- Repeat audits of patients taking medicines to reduce their blood pressure and reduce risk of heart disease showed that prescribing was monitored to ensure correct doses of these medicines were prescribed to reduce risk of adverse reactions.
- Audits undertaken to ensure clinicians maintained the appropriate treatment for patients identified either with kidney disease or at risk of developing kidney disease.
- The composition of the daily duty team reviewed to become more responsive to demand. This was achieved with the appointment of a second paramedic to work in the team. Both paramedics were training to become prescribers.
- The home visiting service was more responsive by using paramedics to visit in the morning. If the patient visited required hospital admission this could be organised earlier in the day to ensure the patient was admitted at a reasonable time.
- Improvements had been made for arranging visits to local care home. Visiting GP now uses a laptop computer with patient records and care plans available to inform care and these can be updated whilst with the patient at the care home.

Any additional evidence or comments

- A multi-disciplinary QOF team had been established to monitor progress on achieving reviews of patients with long term conditions. The team produced regular reports on achievement and managed the recall system to encourage patients to attend for the reviews of their long term condition.
- There was a GP leading on achievement of QOF indicators.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
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.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There was a clinical supervision and mentoring programme in place for nurse prescribers, pharmacists, paramedics and physician associates. • The induction checklists we reviewed were comprehensive and tailored to meet the needs of staff in various disciplines. 	

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)	Y
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.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y

Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The sample of 10 care plans we reviewed showed them to be comprehensive and clear. There was evidence of care plans being shared with relevant professionals. For example, with the out of hours service and with district nurses. 	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice referred patients, when appropriate, for support in weight management and smoking cessation. GPs could also refer patients for exercise programmes. There were screening programmes in place for patients at risk of developing diabetes or dementia. 	

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) <small>(QOF)</small>	93.4%	94.3%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.9% (24)	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.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice held training for all staff to support their knowledge of undertaking assessments of capacity of patients to consent to treatment.• Staff we spoke with had a clear understanding of the law regarding consent from patients aged under 16.	

Caring

Rating: Good

We did not check whether this practice was providing caring services because patient feedback and monitoring indicated no change since the last inspection. The rating from the last inspection has been carried forward.

Responsive

Rating: Outstanding

We did not check whether this practice was providing responsive services because patient feedback and monitoring indicated no change since the last inspection. The rating from the last inspection has been carried forward.

Well-led

Rating: Outstanding

The practice had maintained the rating of outstanding for providing well-led services. Governance and management systems had been consolidated during a period of rapid growth in registered patients. This included taking on a branch surgery known as Whitley Villa.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

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

Explanation of any answers and additional evidence:

- There was a clearly set out and well-structured business plan in place. This had been developed by the leaders in the practice. It also took account of staff views and was shared with staff.
- We spoke with a total of 14 employed staff. All told us they found leaders in the practice approachable and supportive. Employed clinical staff told us they received clinical supervision and mentoring.
- The management structure was undergoing change. The previous senior nurse partner and practice manager partner had left, and a fourth GP partner would replace the partners that had left. One of the GP partners had achieved a management diploma. It was too early to evaluate whether the changes would enable the practice to further develop management and governance processes.
- The practice had been approved as a stand alone primary care network and plans for using

the financial resources available to primary care networks were being developed.

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The business plan set out the practice aims and objectives to sustain high quality care. • Consideration was given within the plan to succession planning • Staff were involved in auditing and managing workload. There was evidence of staff influencing numbers in workforce. When staff identified that more time was needed for administration tasks leaders responded by making resources available and recruiting more administration staff. 	

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.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
Explanation of any answers and additional evidence: <p>We spoke with a total of 14 members of staff during the inspection.</p> <ul style="list-style-type: none"> • The practice had appointed speak up guardians to support staff who wished to raise any concerns they encountered during their duties. 	

- All staff had personal improvement plans agreed as part of their appraisal process.
- Staff we spoke with told us that leaders were approachable and helpful. They were aware that there was a lead GP on duty each day at both sites. All staff said their training needs were met and that accessing training was easy. Developing skills and expertise was encouraged.
- The practice focus on providing high quality, sustainable, care had been maintained during a period when the number of patients registered at the practice had increased by over 10,000.

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

Source	Feedback
Staff interviews	Staff felt encouraged to develop. For example, the physicians associate was mentored, and their achievement recognised by being appointed physician associate ambassador for Thames Valley.
Staff interviews	Staff said they identified the practice as a centre for learning.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Staff were involved in auditing and managing workload. • There was evidence of staff influencing the composition of the workforce to ensure there were enough staff on duty to provide high quality care. • There was evidence of close working with community teams and specialist services. For example, university mental health services. The practice liaised with specialists in mental health from Reading University to support the needs of student patients registered at the practice as well as those registered elsewhere. • Governance systems and processes had been applied consistently to include the second site, Whitley Villa Surgery, since this site was taken on in 2016. 	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Health and safety assessment processes were well established to identify, manage and mitigate risks. Regular updates of risk assessments were undertaken. • The practice business plan incorporated risk analysis of future plans. • Risk management processes were applied consistently across both sites managed by the practice. • The staff handbook incorporated a section on performance management procedures. 	

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There was evidence of the practice using data to improve performance. For example, QOF data informed improvements in recall processes for patients with long term conditions. Data relating to cervical cytology screening was also used to inform a targeted campaign to increase uptake of this screening programme. • Benchmarking data provided by the local CCG was kept under review and action was taken to 	

improve performance that did not meet benchmark standards. For example, in improving care for patients diagnosed with diabetes.

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.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Patient feedback from all sources was consistently positive. This included the national GP patient survey, NHS choices, friends and family test and the 38 patients that provided feedback during the inspection (either personally or via CQC comment cards). The practice had responded to patient feedback by introducing more book in advance appointments enabling patients to book appointments with their preferred GP. We noted that eight of the 33 patients who completed CQC comment cards complimented the practice for providing continuity of care. • Changes were implemented in the referral system to make the booking of hospital appointments more straightforward for patients. • The information on the practice website for foreign students was enhanced to take account of the rising numbers of this group of patients attending the local university. 	

Feedback from Patient Participation Group.

Feedback
<p>We spoke with one member of the patient participation group (PPG). They told us:</p> <ul style="list-style-type: none"> • The PPG had expanded since the practice extended invitations to feedback via electronic communications in addition to the core PPG group that continued to meet. • Meetings were scheduled at different times of the day to accommodate the personal commitments of members. • The practice was responsive to feedback from the PPG. For example, PPG members commented that seating more suitable to the needs of patients who found difficulty lowering into and rising from chairs was needed in waiting rooms. The practice purchased and installed higher seats with arm rests within weeks of the PPG comments. • The practice discussed proposed service changes with the PPG and sought their feedback about such proposals. For example, when the merger with another practice took place in 2016. • When practice service developments were proposed the PPG was consulted. For example, the practice asked PPG members whether they felt appointment for blood tests on Saturday morning should be introduced. • PPG members were asked to contribute topics for the PPG meeting agenda before each agenda was finalised.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• There was a culture of improvement and development at the practice. When changes in service or new services were introduced the practice monitored implementation and sustainability. For example, response times to answering telephone calls was monitored. The quality of telephone interaction with patients was also sampled. Samples of consultations carried out by salaried GPs and other clinicians were reviewed by partners to ensure quality and effectiveness.• Learning from events, complaints, safety alerts and audits was shared via a comprehensive and well established team meeting and briefing structure. Learning was recorded in detail and shared with staff who were unable to attend meetings.	

Examples of continuous learning and improvement

- Since introducing the call centre to receive patient telephone calls the practice had monitored performance of the time taken to answer calls. More staff time has been allocated to keep call waiting to a minimum.
- A virtual diabetes clinic was introduced with the local diabetes consultant to improve care for patients diagnosed with diabetes who were having difficulty managing their condition. This has resulted in a 3.6% reduction in the levels of blood sugar (lower blood sugar levels indicate better control of diabetes). The improvement has been achieved during a period when the number of patients diagnosed with diabetes increased by 20%. Benchmarking data showed the performance to be the best in the locality.
- The year of care system, involving patients with long term conditions setting their treatment targets, has been expanded to include a range of long term conditions. Patients with more than one long term condition have their reviews coordinated to reduce the number of attendances at the practice.
- The practice was a designated training centre for paramedics in primary care and offered practice nurse training opportunities.
- Physician associate training was sponsored by and offered at the practice.

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.
- 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.