

# Care Quality Commission

## Inspection Evidence Table

### Dr R W Shelly & Partners (1-549101303)

Inspection date: 25 April 2019

Date of data download: 18 April 2019

## Overall rating: Good

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

### 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

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) (01/01/2018 to 31/12/2018) <small>(NHSBSA)</small>	0.60	0.67	0.79	No statistical variation

## Older people

## Population group rating: Good

### Findings

- The practice had access to a designated Proactive Care Team made up of a nurse and care co-ordinator. The team was responsible for the care planning, empowering patients, discharge support, and signposting for the practice population identified as the most likely to be admitted to hospital.
- The Proactive Care Team also followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice 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 suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- The practice supplied patients diagnosed with asthma with a 'Your asthma action plan' leaflet. The leaflet allowed for patients to include details about their everyday asthma care, identify what to do if their condition deteriorates or suffer an asthma attack. The leaflet was produced by Asthma UK and can provide healthcare professionals with useful information about a patient's asthma treatment plan. The leaflet can also be used for children and be shared with schools for improved awareness about a child's asthma care plan.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on	77.7%	78.9%	78.8%	No statistical variation

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>				
Exception rate (number of exceptions).	14.0% (115)	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 to 31/03/2018) <small>(QOF)</small>	70.9%	77.0%	77.7%	No statistical variation
Exception rate (number of exceptions).	10.6% (87)	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) <small>(QOF)</small>	84.2%	81.5%	80.1%	No statistical variation
Exception rate (number of exceptions).	17.5% (143)	16.0%	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>	75.4%	75.7%	76.0%	No statistical variation
Exception rate (number of exceptions).	23.8% (276)	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) <small>(QOF)</small>	90.7%	90.0%	89.7%	No statistical variation
Exception rate (number of exceptions).	20.5% (47)	15.2%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension	88.8%	81.7%	82.6%	Tending towards

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)				variation (positive)
Exception rate (number of exceptions).	7.2% (211)	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)	92.8%	91.2%	90.0%	No statistical variation
Exception rate (number of exceptions).	8.6% (30)	6.2%	6.7%	N/A

### Any additional evidence or comments

On review of the practice's Quality and Outcome Framework data, the practice told us it was aware of its higher than local and national averages for exception reporting rate for patients diagnosed with asthma and requiring an annual review. The practice told us this was most likely because it had not previously recorded and coded those patients provided with the Asthma UK 'Your asthma action plan' pack.

As this inspection took place after the national submission date of 2018-19 QOF data, the practice was able to provide up to date, but as yet unverified, performance data with regards to its exception reporting as follows:

- The exception reporting rate for 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 15%.
- The exception reporting rate for 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 9.3%.
- The exception reporting rate for 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 15.1%. This indicates an improvement on the previous year's data as documented above.
- The exception reporting rate for 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 three RCP questions was 26.8%. This represented an increase on the previous year's data as documented above and could be mitigated by the practice's rationale above regarding its unrecorded use of the 'Your asthma action plan' pack.
- The exception reporting rate for the percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months was 15.5%. This indicates an improvement on the previous year's data as documented above.
- The exception reporting rate for the percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less was 7.2%.
- The exception reporting rate for those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more and currently treated with anti-coagulation drug therapy was 5.1%.

**Families, children and young people**

**Population group rating: Good**

**Findings**

- Childhood immunisation uptake rates were above the World Health Organisation (WHO) 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.
- 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)	167	169	98.8%	Met 95% WHO based target (significant variation positive)
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)	162	169	95.9%	Met 95% WHO based target (significant variation positive)
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)	165	169	97.6%	Met 95% WHO based target (significant variation positive)
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)	165	169	97.6%	Met 95% WHO based target (significant variation positive)

**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.

- 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)	79.6%	76.1%	71.7%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	77.8%	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)	66.2%	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)	81.1%	74.7%	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)	43.8%	54.0%	51.9%	No statistical variation

### 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 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. The practice maintained a register for patients living with dementia, which contained 234 patients at the time of inspection.
- All staff had received dementia training in the last 12 months.

<b>Mental Health Indicators</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
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) <small>(QOF)</small>	96.0%	87.6%	89.5%	No statistical variation
Exception rate (number of exceptions).	16.7% (15)	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) <small>(QOF)</small>	92.8%	88.2%	90.0%	No statistical variation
Exception rate (number of exceptions).	23.3% (21)	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) <small>(QOF)</small>	85.0%	82.5%	83.0%	No statistical variation
Exception rate (number of exceptions).	5.0% (11)	6.6%	6.6%	N/A

**Any additional evidence or comments**

As this inspection took place after the national submission date of 2018-19 QOF data, the practice was able to provide up to date, but as yet unverified, performance data with regards to its exception reporting

as follows:

- The exception reporting rate for the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 20.9%
- The exception reporting rate for the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 8.1%.
- The exception reporting rate for the percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months was 4.7%.

## Monitoring care and treatment

**The practice had a programme of quality improvement activity but this was not practice-driven. It did not routinely review the effectiveness and appropriateness of the care provided.**

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	552.1	538.3	537.5
Overall QOF exception reporting (all domains)	6.4%	5.4%	5.8%

## Any additional evidence or comments

As this inspection took place after the national submission date of 2018-19 QOF data, the practice was able to provide evidence of its recent 2018/19 overall QOF score. The practice had again achieved 552 points out of a total of 559.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice provided evidence of some generic audits but these did not demonstrate the practice were using its own internal audits to drive improvement. For example, audits had been completed in association with the practice's participation in the WISDOM project or by the local clinical commissioning group's medicines management standards.</p> <p>Since inspection, the practice has told us it completed an audit of patients who had an acute exacerbation or hospital admission with asthma. As a result of this audit the practice was introducing care plan/help guides to give out during annual reviews and it plans to re-audit this after 12 months. However, we were not provided with any data for this audit.</p> <p>The practice has told us it plans to discuss ideas for future audits at its next clinical meeting.</p>	



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

- An anticoagulant use in high risk patients audit was undertaken in 2015 and 2017 to review patients with atrial fibrillation (AF) were receiving appropriate anti-coagulation treatment. In 2015, the practice identified 375 patients diagnosed with AF, and 234 of those were taking an anti-coagulant medicine. Following the audit, a further 12 patients had been started on anti-coagulant therapy. In 2017, a similar audit identified 417 patients had an AF diagnosis, 278 of those were receiving anti-coagulant therapy, and a further four patients were commenced on anti-coagulant therapy following the repeat audit.
- A Warfarin Patient Safety audit was undertaken in 2015 and 2017 to review patients with atrial fibrillation and ensure the best anti-coagulant therapy was being used. In 2015, 58 patients were reviewed, 52 were eligible for a change in medication. Of those 52, seven patients were transferred to NOAC. In 2017, a further five patients had their medications changed to a more suitable anti-coagulant alternative.

### Effective staffing

**The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles. However, there was limited evidence of clinical supervision of the practice's nurse practitioners.**

	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.	Partial
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence:	
During conversations with some of the practice's healthcare assistants, we were told the Care Certificate for Health Care Assistants (HCA) had been started in 2018. However, due to unforeseen circumstances with the external provider, this had been stopped. We were unable to ascertain what the	

practice had done in response to this. The practice employed four HCAs.

During the inspection, we found the practice had no evidence of regular formal clinical supervision of its nurse practitioners, outside of their annual appraisals. However, we were told one nurse practitioner had not had an appraisal since 2017. We were told nurse practitioners had a GP mentor, they worked alongside the duty doctor during the day and could access clinical advice or support as and when it was required. Since inspection, the practice has reviewed its formal clinical supervision arrangements and updated its policy accordingly. On review of the revised policy, the practice stipulated that nurse practitioners would now have a quarterly meeting with their mentor when a minimum of three random consultations would be reviewed.

All other clinical staff at the practice had been allocated an appropriate mentor. Staff appraisals had all been completed within the previous 12 months.

During the inspection, we requested a copy of the practice's training log. We were told the practice did not maintain their own live document but had access to all staff training via its online training provider, Bluestream Academy. On request, the practice was able to obtain a copy of training log for the whole practice. On review, we found:

- Out of 53 members of staff, all but one member of staff had received Basic Life Support training. The remaining staff member was already booked to receive BLS training on 2 May. The practice has since confirmed this training has been completed.
- All 53 members of staff had completed Fire Safety training within the previous 12 months.
- All 53 staff members were recorded as having completed Infection Prevention and Control (IP&C) training. Clinical staff were recorded as completing this training on annual basis, while non-clinical staff were every two years. The practice's own IP&C did not stipulate the frequency of staff training, but its IP&C Annual Statement stated all staff received annual training. (An IP&C Annual Statement is required by the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance to demonstrate compliance with infection prevention and control practices).
- Information Governance (IG) training had been completed by all but one member of staff. The remaining member of staff requiring IG training started at the practice three weeks previously.
- Out of 53 members of staff, all but one staff member had completed safeguarding children training that was relevant to their role. However, the practice was able to provide evidence of the remaining staff member completing the required training in a face-to-face format in March 2019.
- Out of 53 members of staff, all but one staff member had completed safeguarding adults training that was relevant to their role. The practice was not able to demonstrate whether or not this training had been booked.

Since inspection, the practice has confirmed the member of staff was a GP Registrar that was recently attached to the practice for a rotation period. (A GP Registrar is a qualified doctor who is continuing their training to become a GP). The practice confirmed it was informed that the GP Registrar's training was up to date prior to arriving at the practice but had not yet been provided with the appropriate evidence of this.

## 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

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
Explanation of any answers and additional evidence:	
The practice told us it routinely suggested and referred patients to local and national initiatives, such as Healthier You, Diabetes UK, WISDOM & WISER programmes for diabetes; Asthma UK; Healthy Walks; Weight Watchers and Slimming World; and Alcoholics Anonymous, as well as the local gym and fitness centre. (WISDOM stands for West Hampshire Integrated Shared Diabetes Outcome Measures, while WISER stands for West Hampshire Interactive Structured Education Refresher. Both have been commissioned by the local clinical commissioning group to proactively help patients with diabetes or pre-diabetic symptoms).	

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)	95.9%	94.3%	95.1%	No statistical variation

Exception rate (number of exceptions).	1.7% (73)	0.7%	0.8%	N/A
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**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

# 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.	Yes
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
Explanation of any answers and additional evidence:	
<p>We were told that wheelchair users were being encouraged to specifically request an appointment for room 14 at the Stokewood Surgery site when contacting the practice for phlebotomy or other health care assistant services. This was due to room 14 being a larger room and more capable to accommodate a wheelchair. In order for this request not to be solely dependent on the patient remembering to make this request, we checked with staff at the practice who assured us that alerts were being added to records of patients using wheelchairs to book them appointments in the larger room.</p> <p>When travelling to the practice's branch site, we found the postcode listed for the branch site to be incorrect. This had been listed on the practice's website and the practice leaflet. We raised this with the practice on the day, and following a review of the practice's website in the days following the inspection, we could confirm that the correct postcode has been added.</p>	

Practice Opening Times	
Day	Time
Stokewood site 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
Old Anchor branch site opening times:	
Monday	8.00am-5.30pm
Tuesday	8.00am-5.30pm
Wednesday	8.00am-5.30pm
Thursday	8.00am-5.30pm
Friday	8.00am-5.30pm

### Any additional evidence or comments

The practice offered extended hours for pre-bookable appointments at the Stokewood Surgery site Monday to Thursday from 6.30pm to 7.00pm. The practice also offered pre-bookable appointments in the morning of the first Saturday of each month.

On the day of inspection, 25 April 2019, we asked the practice to confirm its appointment availability. At 1.50pm, we found:

- The next available routine GP appointment was 29 April 2019 at 9.40am at the Stokewood Surgery site.
- The next available routine nurse appointment for a minor illness appointment was the same day as the inspection at 4.50pm.
- The next available routine nurse appointment for an asthma review was 20 May 2019, where there were at least two appointments, both at the Old Anchor branch site.
- The next available routine health care assistant appointment for a blood test was the same day as the inspection at 6.30pm at the Stokewood Surgery site.

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
17,662	234	107	45.7%	0.61%

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)	95.6%	96.3%	94.8%	No statistical variation

### Older people

### Population group rating: Good

#### Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- 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.
- There was a medicines delivery service for housebound patients.

## People with long-term conditions

Population group rating: Good

### Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- 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

- Additional practice nurse appointments were available until 7.00pm Monday to Thursday for school age children so that they could attend outside of school hours.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

## Working age people (including those recently retired and students)

Population group rating: Good

### Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 7.00pm on Monday to Thursday. 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.

## People whose circumstances make them vulnerable

Population group rating: Good

### Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- 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.

**People experiencing poor mental health (including people with dementia)**

**Population group rating: Good**

**Findings**

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice became a Dementia Friendly accredited practice in February 2019.
- 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.**

	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
Explanation of any answers and additional evidence: The practice had created an Urgent Care team to manage on the day appointment requests. The Urgent Care team was made of duty GPs and nurse practitioners. Patients contacted the practice, receptionists received the call and added the patient, if indicated, to the triage list. The Urgent Care team would return calls to the patients and triage the symptoms over the telephone with the patient themselves. If an appointment was required that day, this would be made with the most appropriate clinician, either the Duty GP or one of the nurse practitioners. If an appointment was not required that day, the Urgent Care team informed patients what to do as an alternative, either self-management, attending a local pharmacy or booking the patient in with their usual GP within a few days.	

**National GP Survey results**

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	56.4%	N/A	70.3%	No statistical variation
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)	54.8%	74.7%	68.6%	No statistical variation



Indicator	Practice	CCG average	England average	England comparison
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)	47.4%	68.6%	65.9%	Tending towards variation (negative)
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)	65.2%	78.7%	74.4%	No statistical variation

### Any additional evidence or comments

The practice confirmed it was aware of patients' feedback regarding access to and the types of appointments available. To improve this, the practice had taken the following steps:

- The practice introduced e-Consult in 2017. (e-Consult allows patients to consult online with their own GP as well as seek self-help advice and be signposted to other health services). As of January 2019, the practice was identified as the fourth highest user of e-Consult in the West Hampshire clinical commissioning group area, out the 35 practices signed up to use e-Consult.
- The practice had introduced Urgent Care clinics. These clinics offered appointments for on-the-day, urgent matters. Patients could contact the practice, they would be added to the triage call list and a call back would be made to the patient, either by a GP or a nurse practitioner. An appointment would then be made according to the patient's concern or issue, whether it be on the same day with a member of the urgent care team or with the patient's own GP within the following days. The practice stated the triage list was staffed by two GPs and two nurse practitioners every weekday morning, and one GP and one nurse practitioner every weekday afternoon.

The practice provided evidence of recent Friends and Family Test (FFT) responses it had received since July 2018.

- During the period between July 2018 and April 2019, 1014 responses were received. Of those 1014 responses, 91% confirmed they would recommend the practice to others, while 6% said they would not recommend.
- During the same period, the practice received 791 five-star ratings, 129 four-star ratings, 24 three-star ratings, 20 two-star ratings, 44 one-star ratings and 6 zero-star ratings via its FFT system.

### CQC comments cards

Total comments cards received.	39
Number of CQC comments received which were positive about the service.	26
Number of comments cards received which were mixed about the service.	11
Number of CQC comments received which were negative about the service.	1

Source	Feedback
CQC Comment	Comments cards which contained positive comments reported appointments were

cards	<p>available to suit patients, while emergency appointments were always available. Patients started they were happy with their appointments.</p> <p>Comment cards which contained mixed comments reported some confusion about where appointments were held, for example, going to the Stokewood site and finding out their appointment was at the Old Anchor branch site. Other comments referred to long waits to see a specific GP, or appointments running late.</p> <p>Negative comments reported difficulty in getting an appointment.</p>
NHS UK website	<p>On the NHS UK website, the Stokewood Surgery site was rated 3 out of 5 stars for appointments in 21 reviews, and 3 out of 5 stars for telephone access in 21 reviews. Comments made by some patients referred to appointments being available as required, while others reported long wait times for an appointment, up to a month in advance to match own availability, or appointments running late with no notice from reception staff to patients waiting.</p> <p>The Old Anchor branch site was rated 2 out of 5 stars for appointments in 4 reviews, and 1 out of 5 stars for telephone access in 3 reviews. Comments varied from long waits for appointments to appointments being on time.</p>

#### Any additional evidence

One comment card received for this inspection was blank.

#### 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.	27
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Example(s) of learning from complaints.

Complaint	Specific action taken
Prescription error.	Following receipt of this complaint, the practice also raised and investigated this issue as a significant event. The patient involved was contacted, apologised to and informed of the outcome of the significant event and its associated learning for this type of error to not be repeated. The significant event resulted in a change to the practice's policy in prescribing

	medicines under shared care arrangements.
Triage of young patient, less than three months of age.	Following receipt of this complaint, the practice also raised and investigated this issue as a significant event. The family involved was contacted, apologised to and informed of the outcome of the significant event and its associated learning for this type of error to not be repeated. The significant event resulted in a change to the practice's policy regarding the appropriate triage of children less than three months of age.

## Well-led

## Rating: Requires Improvement

We rated the practice as requires improvement for providing well-led services because:

- Systems and processes were not effectively established to ensure compliance with the requirements to demonstrate good governance.

### Leadership capacity and capability

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

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

### Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: We saw clear evidence which demonstrated the practice had a vision for a sustainable future and were embracing new ways of working to support this and improve its current services. For example, the practice was part of a GP Federation hub which provides extended access to GP services for its patients; the practice was part of a cluster of local GP practices. The practice had introduced e-Consult and an Urgent Care Clinic with nurse practitioners being added to its clinical team to increase clinical availability for urgent, on the day matters.	

### 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
Explanation of any answers and additional evidence: The practice told us they had an agreement with a local practice who provided a 'Freedom to speak up' champion. This meant the staff working at the practice had an external individual they could contact if they had concerns they wished to raise about the practice, and did not wish to do so within the practice. (A 'Freedom to Speak Up' champion acts as a point of contact for individuals who require advice and support outside of their usual work environment).	

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

Source	Feedback
Staff interviews	Staff we spoke to on the day of inspection told us they enjoyed working at the practice, many of the staff had been at the practice for many years. Staff confirmed they were confident the practice would address concerns as and when they were raised. Staff felt supported by colleagues, managers and GPs, and confirmed that an open-door policy was in place if anyone needed assistance. Staff told us they would like to have more whole practice meetings, rather than one Annual General Meeting a year. They felt this would promote closer working relationships with the other teams in the practice and ensure essential changes were communicated consistently.

#### Governance arrangements

**There were responsibilities, roles and systems of accountability to support governance and management. However, during the inspection, we found gaps in the practice's governance structures which meant full oversight was not in place.**

	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
Explanation of any answers and additional evidence: We saw evidence which showed the practice were appropriately reporting significant events via an online reporting tool, known as Datix. However, on review of a selection of significant events we saw limited evidence to demonstrate that these had all been appropriately investigated or shared with relevant practice staff. For example, a possible theft of medicines within the practice was not known by all staff. We raised this with the practice on the day, and it has since confirmed a repeat investigation into certain significant events has taken place and been recorded on Datix. The practice also confirmed more in-depth reporting of significant events would take place to ensure appropriate learning had been gained, and then shared with relevant staff.	

During the inspection, we found the practice was receiving and acting upon safety alerts but there was limited evidence of a full loop closure regarding safety alerts. For example, we saw evidence of a spreadsheet but it had not been appropriately completed to demonstrate that all alerts had been actioned. When asked regarding two safety alerts, the practice confirmed they were aware of the first alert but not the second. However, clinical staff confirmed they were already performing the actions as directed in the second alert. Since inspection, the practice reported a GP partner had been identified as lead for all safety alerts and would oversee the centrally-held spreadsheet to record all safety alerts and document that appropriate action taken by the practice in response to the alerts.

To monitor families that had safeguarding concerns, the practice told us they had decided to add alerts to the records of family members. This had been so that all staff were aware of those families, if the child, young person or family member with a safeguarding concern was attending the practice. However, while demonstrating this to the inspection team, it was found that these alerts had not been consistently added to patient records. On discovering this error, the practice acted and had completed this action by the end of the inspection day.

On review of the practice's patient group directives (PGDs) we noted several of the documents had been signed the day before the inspection, despite having been valid for several months. In discussion with the nursing team, the practice reported that its previous method of being informed of expiry dates had failed, and it was only via a manual search that expired PGDs had been found. The practice confirmed a new fail-safe system was required and decided that a monitoring spreadsheet was required for the nursing team to check monthly to and action if an expiry date was due within the following month. We have since seen evidence of this spreadsheet.

### Managing risks, issues and performance

**There were processes for managing risks, issues and performance but the overall oversight was not consistent and the use of clinical or internal audits to drive improvement was not consistently 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.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: There was limited evidence to demonstrate full oversight of the entire practice was in place and was, therefore, effective. We saw evidence of systems not being effectively implemented despite the practice's assurances they had been. For example, the use of safeguarding alerts of family members' records not being consistently in place, or the incomplete investigation of a possible theft within the practice.	

There was limited evidence of a systematic programme of clinical and internal audits to drive improvements. Audits were completed but these audits were either stipulated by an external initiative or by an external stakeholder, such as the local clinical commissioning group's medicines management standards.

### Appropriate and accurate information

**There was a commitment to using data and information proactively to support decision making but this was not consistently demonstrated.**

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>There was limited evidence to demonstrate full oversight of the entire practice was in place and was, therefore, effective. For example, full oversight of safety alerts did not appear to be in place at the time of inspection, significant events had not been thoroughly investigated to ensure all avenues of responsibility and associated learning had been identified and subsequently shared with all relevant staff.</p> <p>The lack of formalised clinical supervision of the practice's nurse practitioners did not allow for performance information regarding their clinical assessment decisions and prescribing practices to be monitored.</p> <p>We found evidence of some members of staff not knowing the full details of their job description. This indicated that staff members could be acting outside of their job description and be accountable for actions that they had not been aware of. Since inspection, the practice has confirmed job descriptions for staff were constantly under review as staff gained experience and knowledge. The practice stated they were confident that no staff member was acting outside of their job description.</p> <p>We saw evidence of the practice instigating a Resilience audit by the local clinical commissioning group, which was self-funded. The audit has helped the practice to identify areas of improvement in line with NHS England's General Practice Forward View programme.</p> <p>We saw evidence of risk assessments being completed at both the main surgery site and at the Old Anchor branch site. For example:</p> <ul style="list-style-type: none"> <li>• Fire risk assessments were completed at the Stokewood Surgery site on 10 July 2018 and the Old Anchor branch site on 3 October 2018.</li> <li>• Burglar/Intruder alarms risk assessments were completed at the Stokewood Surgery site on 26 September 2018 and the Old Anchor branch site on 19 September 2018.</li> <li>• Health and safety risk assessments, such as clinical hazards and the reception area, had been completed but not since 14 August 2017 and 24 August 2016 respectively.</li> </ul>	

## 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
<p>Explanation of any answers and additional evidence:</p> <p>The practice told us it did not have an active face to face patient participation group. Instead, the practice reported an effective virtual patient participation group which the practice told us they accessed regularly when changes were being considered for the service, or patient feedback was required.</p> <p>The practice told us it offered and encouraged all patients to provide feedback. This was done in a variety of ways, such as via a suggestion box in the reception areas of both sites, via a contact form on the practice's website, by responding to the practice's newsletter and via the Friends and Family Test.</p>	

#### Feedback from Patient Participation Group.

Feedback
<p>We sent out emails to six members of the practice's virtual patient participation group (PPG) for feedback about the practice. We received three responses in return, and the information provided by these individuals included:</p> <ul style="list-style-type: none"> <li>• The practice provided regular newsletters by email, which contained information about staff changes as well as plans for the future.</li> <li>• The practice had adapted its services to meet the needs of its practice's population. For example, the practice had introduced an Urgent Care clinic, specific clinics for long-term conditions have been made available and patients can access GP services in Winchester outside of normal GP working hours, reducing waiting times for an appointment from five weeks to a couple of days.</li> <li>• Reception staff were reported to be kind, helpful and welcoming.</li> <li>• Due to the PPG being a virtual group, members reported that there has been no consultations with this Group by the practice in recent years and the most recent Local Participation Report that is available on the practice's website is for 2014/15 based on the Stokewood Surgery Action Plan for 2015.</li> <li>• Some of the PPG felt, outside of the occasional surveys that are undertaken on various issues, there were limited opportunities for patients to engage with the practice.</li> <li>• However, the practice was reported to be open and transparent via its use of the regular newsletters.</li> <li>• There were reports of a high turnover of staff that had been detrimental to those patients with long-term conditions who benefit from continuity and a trust-based relationship with their GP.</li> </ul>

#### Any additional evidence

Following feedback from the patient participation group regarding a recent turnover of staff, the practice has since confirmed it used two GP locums for two planned long-term absences, and it had sourced



additional locum GP cover for two episodes of unexpected absence in the previous 12 months. The practice also confirmed it had recruited new salaried GPs to add to its current staffing levels and was not as a result of loss of staff.

## Continuous improvement and innovation

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

	Y/N/Partial
There was a focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice was registered as a GP training practice in August 2018. At the time of inspection, there was one registered GP trainer in the practice, with another GP undertaking their GP trainer training. Also, at the time of the inspection, the practice had one GP registrar attached to the practice.</p> <p>The practice organised and held educational sessions for patients to attend. One such session, held in the spring of 2018, was regarding Osteoporosis. The practice had arranged for a national Osteoporosis speaker to attend and provide information to patients regarding support, improved lifestyle choices and better self-care management techniques.</p> <p>The practice has introduced the AccuRX text messaging system. (AccuRX is free, easy-to-use messaging service frequently used by GP practices which allows practice staff to instantly send text messages to patients). The practice used this system to communicate normal and routine test results to patients via text message, rather than a telephone call being required. The practice confirmed it did not provide this service for patients aged five to 16 years old.</p> <p>We saw evidence which indicated that learning from significant events was not consistently being shared with relevant parties within the practice. For example, during our conversations with staff members, not all clinical staff had been made aware of the event in which medicine had gone missing from the practice's emergency drug stock.</p> <p>The practice had introduced Docman 10 in January 2019 to support clinicians with their administrative tasks. (Docman 10 is cloud based software platform that manages incoming clinical correspondence).</p>	

#### 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.