

Care Quality Commission

Inspection Evidence Table

Cirencester Health Group (1-556469798)

Inspection date: 26 May 2022

Date of data download: 12 April 2022

Overall rating: Good

Safe

Rating: Good

At the last inspection we rated Safe as Requires Improvement because:

- When we carried out remote searches of patient records we found there were gaps in systems of monitoring patients consistently prior to the prescribing of medicines and the completion of medicine reviews. For example, patients prescribed Leflunomide had not had the required monitoring which included blood pressure and weight checks.
- There was a backlog in summarising patient records.
- We saw patient confidential and personal information had not consistently been stored securely.

At this inspection, we saw evidence of required improvements from the last inspection:

- We found the monitoring and prescribing of patients had improved.
- The backlog of patient records requiring summarising had been significantly reduced.
- Confidential information was now stored securely in line with best practice guidance.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes

Safeguarding	Y/N/Partial
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice continued to review the number of patients attending minor injuries units or the emergency department. Information regarding any concerns about the attendance were raised with the patient's named GP and at the weekly clinical meeting as a standing agenda item. This meant that any safeguarding concerns linked with this attendance would be identified and action taken promptly. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: July 2021	Yes
There was a fire procedure. Date of fire risk assessment: February 2022	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> At the last inspection, we found concerns around staff not having a complete understanding of what to do in the event of a fire. At this inspection, we found the practice had developed comprehensive systems to embed fire and major incident learning for all staff. We found they had: <ul style="list-style-type: none"> Fire training and major incident plan training added to mandatory six-monthly training A fire awareness section was added to new staff induction training. A twice-yearly fire drill was practised, and times were recorded and targeted to improve on previous response times. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out.	Yes

Date of last infection prevention and control audit: August 2021	
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> All staff had received infection prevention and control training at a level appropriate to their role. Throughout the COVID-19 pandemic the practice had followed guidance on enhanced infection control measures and staff had been regularly updated on changes to working practice. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• At our last inspection, we found a two-month backlog in the summarising of patient records which equated to 228 patient records. After the last inspection, the practice developed an action plan and estimated an eight-week target for notes to be summarised.• At this inspection, we found that the practice had recruited additional staff to reduce the backlog. While 71 records remained uncompleted, the practice was actively pursuing those patients who had no notes. We could see documented evidence of the practice contacting the national medical records courier network to expedite the transfer of those patients whose records were delayed.• The practice conducted a monthly summarising audit to review progress and make changes. For example, the practice changed its registration process for immigrants and newborns to make it easier for new parents to register.	

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) (01/01/2021 to 31/12/2021) (NHS Business Service Authority - NHSBSA)	0.60	0.74	0.76	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2021 to 31/12/2021) (NHSBSA)	9.6%	9.7%	9.2%	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 (01/07/2021 to 31/12/2021) (NHSBSA)	5.46	5.41	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	144.2‰	130.7‰	129.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) (NHSBSA)	0.61	0.66	0.62	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	7.8‰	7.5‰	6.8‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<ul style="list-style-type: none"> We undertook a remote review of a sample of patient's clinical records in relation to the use of medicines including high-risk medicines and found that there were systems in place for monitoring patient's health and these were completed in the required timeframes in order to keep patients safe. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	14
Number of events that required action:	11

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

Event	Specific action taken
Incorrect pathology request form sent to pathology and patient blood samples were rejected.	All staff were reminded in meetings and email to ensure the Pathology Laboratory receive clear instructions to avoid a further unnecessary rejection.
Incorrect transportation of blood samples to local hospital.	All staff were reminded of correct procedure and for staff not to book tests in for this hospital.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> At the last inspection, we found issues around the management of safety alerts for couple of medicines: Amlodipine (a medicine used to treat high blood pressure) and Simvastatin (a medicine used to treat high cholesterol). <ul style="list-style-type: none"> At this inspection, we found the practice had improved its alert and review period. We could see that all eligible patients had been changed to a more appropriate and safe medicine. 	

Effective

Rating: Good

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

Effective needs assessment, care and treatment

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
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">At the last inspection, we found gaps in the monitoring of patients on long-term and high-risk medicines. Following that inspection, the practice's guidelines and processes were reviewed and staff updated on the action they need to take to record all follow-ups and monitoring. For example, the recording of blood pressure results for patients supplied with a home monitoring kit. An audit was carried out to ensure patients were monitored appropriately.At this inspection, we found that a new system of automated batch searching of patients requiring monitoring had been established to strengthen existing systems to ensure those patients were not missed. This meant that patients had additional safety netting to prevent them from being missed for review.	

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified were referred to in-house 'wellbeing at home' team who provided an assessment of their physical, mental and social needs and signposted them to appropriate clinicians and care agencies.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was an appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End-of-life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- At our last inspection, our remote searches found 367 patients who displayed indications they may have atrial fibrillation (a heart condition that causes an irregular and abnormally fast heart rate). For 83 of those patients their records did not evidence the risks from stroke had been addressed or appropriate medicines prescribed.
 - At this inspection, this had been resolved and the practice had developed and strengthened systems and processes for identifying, managing and monitoring those patients with atrial fibrillation. For example, patients on the atrial fibrillation register are coded into anticoagulation therapy unless contraindicated. Where this is identified a more appropriate course of treatment is started.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- The practice invited patients for a review of their long-term medical conditions on their birthday month. For patients who did not attend for monitoring, reminders were sent by text, email and letter.

- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding on care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example, diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with the newly diagnosed cardiovascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England)	92	98	93.9%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England)	114	121	94.2%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England)	115	121	95.0%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England)	117	121	96.7%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England)	107	113	94.7%	Met 90% minimum

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

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 30/09/2021) (Public Health England)	75.0%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (PHE)	36.6%	65.8%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (PHE)	68.8%	71.0%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (PHE)	59.3%	60.1%	55.4%	No statistical variation

Any additional evidence or comments

- Additional clinics had been implemented to provide more appointments for patients to attend for cervical screening.
- Two additional practice nurses had completed their cervical screening training to increase staff resource to deliver smear testing. This would provide additional appointments and improved access for patients to attend for cervical screening.
- The patient care coordinator monitored and contacted patients who were overdue for their cervical screening. Patients who did not attend for their appointment were contacted to encourage them to rebook.

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.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

- As part of the Greener Inhaler Prescribing project, the practice undertook an audit of inhaler prescribing. It set out to identify patients who had poorly controlled asthma and also identify unnecessary prescribing of inhalers. The practice planned to reduce the number of patients having six or more Salbutamol inhalers a year. Changes from this audit were stopping the prescribing of two inhalers at a time. This meant if patients felt they required more inhalers this triggered an asthma review to better manage their asthma with appropriate medicine.
- The practice had implemented an electronic system to identify patients who had been admitted to the hospital and those readmitted to ensure they were discussed at weekly clinical meetings and followed up appropriately.

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.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and nursing associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Relevant induction training was provided to all new staff. A record of the induction training was maintained and signed by the new staff member and their mentor.• Staff who had additional or lead roles were provided with appropriate training. For example, additional training had been provided to a member of staff before they carried out health checks for patients living with a learning disability. The infection prevention and control lead had attended regular training. Nursing staff were required to carry out additional training and provide evidence of competency for specific tasks and procedures. For example, nurses who carried out cervical screening had completed additional training and audited the completed screening procedures to ensure they were skilled and competent.• The practice maintained information relating to the skills and competencies of the nursing staff which the reception staff were able to access. This meant they were able to book patients in with an appropriate clinician for their appointment.	

Coordinating care and treatment

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

Indicator	Y/N/Partial
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

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice supported patients to monitor their health. For example, patients at risk from high blood pressure were provided with home monitoring equipment and followed a process to share the information with the practice.• Patients with asthma were provided with peak flow meters to monitor their condition.• The practice provided up-to-date information on their website to help them live healthier lives. This included the contact details of external support groups and organisations.	

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
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes

Responsive

Rating: Not rated

Access to the service

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

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">At our last inspection, we found the leadership team monitored systems and processes to ensure services were developed and provided effectively. However, the monitoring and oversight had not always been consistently effective. For example, the monitoring of patients on complex or high-risk medicines and ensuring all staff attended fire drills.<ul style="list-style-type: none">At this inspection, we found the practice had addressed these concerns with comprehensive action plans and additional processes to ensure staff and patient safety. For example the additional fire training and fire drills for staff.The practice was part of a Primary Care Network (PCN) who were working with the local Clinical Commissioning Group (CCG) to meet the developing needs of the practice and provide a quality service to patients. For example, additional staff had been recruited within the PCN such as a Frailty Team who provided support to the practice.We saw evidence of succession planning. The practice had recruited staff ahead of staff members leaving so there was a period of time for shadowing and a handover. This minimised the potential disruption that could be caused by staffing changes, for example, staff having to cover an additional role whilst new staff are inducted.	

Vision and strategy

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

	Y/N/Partial
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

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice responded verbally and in writing to complaints. The written and verbal responses included an apology when things had gone wrong and information on the action the practice had taken to investigate and/or address the complaint. The practice promoted the wellbeing of staff and were keen to seek feedback. Partners attended staff team meetings, for example, there was a dedicated partner to support the clinical and administration team meetings. This helped to have clear lines of communication between the staff and management of the practice. The wellbeing of staff was included in the practice business plan and reviewed regularly as the practice identified constant vigilance was required to ensure staff were not feeling stressed or becoming 'burnt out' following the COVID-19 pandemic and the associated post-lockdown recovery. At the last inspection the practice had been awarded the Pride in Practice Award (an award that ensures that all lesbian, gay, bisexual and trans people have access to inclusive healthcare that understands and meets the needs of its communities). <ul style="list-style-type: none"> At this inspection we found the practice manager had undertaken training to help improve staff and patient inclusivity. A program of learning was developed to better help staff understand the issues faced by patients with protected characteristics and how to develop services provided by the practice. 	

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

Source	Feedback
Interviews with staff	The staff we spoke with stated they enjoyed working for the practice. During meetings, staff felt involved in the day-to-day issues faced by the practice. Challenges did remain in finding staff to cover an increasingly busy practice. However, staff felt leaders were aware of the challenges facing staffing and were acting to improve this.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice maintained oversight of the quality improvement initiatives and outcomes from the ongoing audit programme. Audits were held on the practice electronic information system and were accessible to all staff. Following the review of the audit, the leadership team identified any action needed and timescales for repeating the audit.• The practice communicated with external organisations regarding the provision of services. For example, communication with the company that collected clinical waste and the company that provided cleaning services to the branch site at the Avenue Surgery.	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• At the last inspection, we found concerns that staff were not familiar with the major incident plan and a significant backlog of patient records requiring summarising. We identified gaps in the monitoring of patients on long-term or complex medicines which left them at risk. At this inspection we found:	

- Staff were aware of the practice major incident plan as it was a part of their induction training and added as a standing agenda item at the team meeting to ensure staff remain familiar with roles and responsibilities in the event of a major incident.
 - The summarising of patient records had been prioritised and an action plan was developed. We saw that all but 71 outstanding records had been summarised with the remaining being actioned or pursued.
 - The practice had reviewed and improved its monitoring of patients on long-term or complex medicines. For example, the practice had improved the monitoring of patients with atrial fibrillation (atrial fibrillation is an irregular and often very rapid heart rhythm). The practice had improved patient coding and those patients are automatically added to the atrial fibrillation register. Once on the register, an improved monitoring process had been established to ensure the most appropriate treatment and monitoring is developed for each individual patient.
- The practice had a lone working policy and procedure and staff did not work alone when there were patients in the building. However, on occasions, when there were no patients in the building a staff member would be working alone at the beginning and end of the day. This was included in the policy and an appropriate risk assessment was in place.
 - When staff carried out home visits, they provided information about their visit to another member of staff and always carried a mobile telephone.
 - Clinical rooms and the reception area had panic alarms which all staff were aware how to use. Staff reported they felt safe and supported by the systems and processes at the practice.
 - The practice carried out audits and work projects to review outcomes for patients and took action when improvement was required. For example, the project on the identification of pre-diabetic and diabetic patients had improved systems to monitor and treat patients.
 - The practice managers met with external stakeholders to ensure systems and processes were effective. For example, the cleaning contractors and the clinical waste collection service.

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes

Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had followed national guidelines to work remotely during the COVID-19 pandemic to protect patients and staff. However, the practice had been open to see patients who were assessed as needing to attend the practice during the pandemic. In response to the national guidelines changing the practice had adapted their way of working. For example, they increased activity in recall of patients for reviews and other screening programmes. Online services had enabled additional methods for patients to contact the practice. Patients who were unable to access these services were able to continue to contact the practice by telephone. 	

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 monitor and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes

Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had a planned programme of staff meetings. Minutes were taken and stored electronically and all staff who could not attend the meeting had access to the information. 	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had initiated a Greener Inhaler Prescribing Quality Improvement Programme. This program recognised that the NHS had a carbon footprint of 21 tons of carbon dioxide, with asthma inhalers contributing to 0.85 tons of the overall carbon footprint. The practice set out to reduce the prescribing of inhalers with a propellant which contributes to these levels. In conversations and agreement with patients, the practice has changed inhalers to more environmentally friendly inhalers and continued good control of asthma symptoms in that patient group. For example, of the 600 patients prescribed inhalers, the practice had prescribed 570 of the more environmentally friendly inhalers. The practice had amended the system for the administration of Shingles vaccines. The practice contacted patients to make an appointment once their shingles vaccine had been received. This avoided cancellations and delays due to the supply of vaccines. The reception staff attended monthly training sessions led by the clinicians. This helped build their knowledge and skills in recognising priority patients and improving the service provided to patients. 	

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **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.
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- ‰ = per thousand.