

# Care Quality Commission

## Inspection Evidence Table

### Cricklade Surgery (1-526584651)

Inspection date: 06 May 2022

Date of data download: 13 April 2022

## Overall rating: Good

At our previous inspection in March 2021, we rated the practice as Requires Improvement. This was because systems to ensure patients received appropriate monitoring were not always effective. Processes to review policies were not effective, for example, information was not brought up to date following changes in guidance or in line with the required review date.

At this inspection in May 2022, we rated the practice as Good because:

- The practice provided care in a way that kept patients safe and protected them from avoidable harm.
- Patients received effective care and treatment that met their needs.
- Patient feedback overall was positive, including access to services.
- Staff had the skills, knowledge and experience to carry out their roles. There was a system in place to monitor compliance with staff training. Staff were encouraged and supported to develop their skills and knowledge.
- The way the practice was led and managed promoted the delivery of high-quality, person-centre care.
- Quality improvements had been made against the action plan from the last inspection.

## Safe

## Rating: Good

At our previous inspection in March 2021, we rated the practice as Requires Improvement for providing safe services. This was because:

- Not all staff had received safeguarding training appropriate to their role.
- Practice arrangements to identify and mitigate risk relating to fire, health and safety and infection control, were not effective.
- Systems to ensure patients received appropriate monitoring were not always effective.
- Patient group directions were not always signed and authorised in line with guidance.
- The practice could not be assured that they held appropriate emergency medicines and equipment.

At this inspection in May 2022, we rated the practice as Good for providing safe services. We found:

- Safeguarding systems, processes and practices were implemented and all staff had received training appropriate to their role.
- Improvements had been made to identifying and mitigating risks relating to fire, health and safety and infection control.

- Patient group directions were signed and authorised in line with guidance
- The practice held appropriate emergency medicines and equipment.
- The provider should make further improvements to induction procedures to ensure training and guidance is available for locum and temporary staff.
- The provider should also make further improvements to ensure staff follow care pathways and protocols evidenced within records for patient medicine reviews.

## 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.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• There was a safeguarding system and policy in place for vulnerable adults and children which was reviewed in April 2022. There were designated safeguarding leads, with local arrangements and key contacts for making a safeguarding referral.</li> <li>• Senior managers discussed safeguarding at regular monthly meetings. Nurse led meetings were held to discuss vulnerable patients as part of the on-going agenda. Relevant information was recorded in patient records.</li> <li>• All staff had received safeguarding training appropriate to their role and this was refreshed when required.</li> <li>• A mixture of clinical and non-clinical staff members had chaperone responsibilities as part of their role. Those staff members had completed relevant training and Disclosure and Barring Service (DBS) checks or risk assessments had also been conducted.</li> <li>• The practice had a system to identify vulnerable patients on record and there were regular discussions between the practice and other community care professionals such as health visitors, social workers and support from the Primary Care Network (PCN).</li> </ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y

Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• There was a recruitment policy in place, which had been reviewed in March 2022. This included how the practice processes personal data in accordance with the General Data Protection Regulation (GDPR). The practice had maintained records in relation to COVID-19 immunisation status as well as other role specific immunisation for all staff.</li> <li>• We carried out recruitment checks in relation to three members of staff which contained all of the required information as per practice policy, including Disclosure and Barring Service (DBS) checks.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: August 2021.	Y
There was a fire procedure. Date of fire risk assessment: 8 July 2021.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Portable appliance testing had been completed in December 2021, whilst equipment calibration had been completed in March 2022.</li> <li>• The practice conducted fire alarm tests weekly, records were maintained to document this. The fire alarm system was connected with the town council building next door and there was a working arrangement for testing fire alarms. The emergency lighting had been competently tested and certified in November 2021 and the fire extinguishers in January 2022. Electrical wiring had been serviced with safety certification issued in September 2021.</li> <li>• The fire risk assessment conducted deemed the premises as compliant, however, there were advisory actions issued. The practice had worked through the action plan and rectified immediate concerns, such as new fire safety signage, replacement of a fire blanket and emergency panic alarms fitted into patient toilets. Actions that had been noted but not yet completed included enclosing the flue pipe to ensure safety (The purpose of the flue pipe is to remove harmful byproducts of the combusted, or burned, fuel from inside the premises). There was a plan to include this remedial work to be conducted at the next boiler service in August 2022.</li> <li>• Health and safety risk assessments had been carried out internally in August 2021. This included visitor security, emergency procedures, lone working and disabled access to premises. This showed quality improvements in the oversight of systems to identify and mitigate risks to service users.</li> <li>• Legionnaire servicing had taken place in April 2021. Records of daily water checks were completed by staff.</li> </ul>	

## 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.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: September 2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The infection prevention and control (IPC) policy was reviewed in March 2022. Standard operating procedures were in place and had been reviewed by the practice's IPC lead. The IPC lead was able to demonstrate a comprehensive understanding of infection, prevention and control and their role in ensuring the practice complied with national guidelines.</li> <li>• Staff were up to date with IPC training.</li> <li>• At the previous inspection in March 2021, the practice's oversight of infection prevention and control was not fully effective. The IPC risk assessment was conducted in February 2021 had not been fully completed and information recorded was not always accurate. At this inspection, we saw that appropriate measures were in place and an infection control audit was completed in September 2021. This indicated that there was sufficient information needed to plan safe care available to staff and patients. Improvements had been made to the risk assessment action plan to include arrangements for clinical waste, guidance for cleaning arrangements, personal protective equipment (PPE) as well as cross infection procedures.</li> </ul>	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Partial
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice had a sole GP provider who was supported by a regular locum GP to ensure cover of sessions were filled and to assist during busy periods including annual leave and sickness.</li> <li>• There was a recruitment policy for new members of staff, but lack of induction procedure for training and guidance for locum and temporary staff. The practice told us they did not employ temporary staff and that their locum GP had worked with the practice for a number of years. The practice utilised support from the PCN for a lead pharmacist and the practice was not solely responsible for training and development for this role. Clinical supervision was given by the practice's lead GP to ensure oversight of performance and safe care and treatment.</li> </ul>	

- There was evidence of staff completing additional training for responding to medical emergencies, for example, sepsis management and awareness.
- At the last inspection in March 2021, the impact of staffing cover on patients had not been assessed. However at this inspection, feedback from staff indicated that there were appropriate systems in place for managing staff absence and appropriate cover for annual leave. We saw that staff rotas for clinical and non-clinical staff were planned six weeks in advance.
- We reviewed the clinician arrangements at the practice's branch site. There was adequate clinical staffing arrangements to ensure in the event of emergency, the risk of unsafe practice was mitigated and that there was no lone working.

## 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.	Partial
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• There was a dedicated administration team of staff who were responsible for summarising records. We found the practice was up to date with summarising patient records.</li><li>• There was a clear documented approach to the management of test results. Staff we spoke with were aware of their roles in relation to test results and tasks were set for clinicians to review these on the same day.</li><li>• During this inspection, we undertook searches of the practice's clinical patient records system and found that information gathered during medicine reviews were not always comprehensive. For example, we reviewed five patients records and found there was limited evidence in three patients records that the required monitoring was up to date to ensure safe prescribing. Assurances were given that the practice retrospectively reviewed these patients to ensure safe care and treatment.</li></ul>	

## 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)	0.99	0.69	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)	7.0%	10.4%	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)	5.74	4.76	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	172.5‰	124.8‰	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)	3.40	0.66	0.62	Significant Variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	5.0‰	5.9‰	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.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y

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.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• At the last inspection in March 2021, we found that the practice were outliers for the prescribing of antibacterial and hypnotic medicines. This had already been identified by the practice as an area for improvement, they were working to reduce the prescribing for those medicines where appropriate and monthly reports were being reviewed by the clinicians.</li> <li>• At this inspection, we found that improvements had been made for antibacterial prescribing. The prescribing of hypnotics was still above local and national averages.</li> <li>• We identified 32 patients prescribed benzodiazepine, a type of hypnotic medicine used to treat sleep disorders. Of the five patients' clinical records we reviewed, three had received appropriate medicine reviews within the last 12 months and had risk reduction discussed. We found that prescribing had been appropriate and in line with national guidance. Two of the five patients had not received medicine reviews within the last 12 months. Assurances were given that the practice retrospectively reviewed these patients to ensure safe care and treatment.</li> <li>• There was a process for the safe handling of requests for repeat medicines and evidence of structured medicine reviews for these patients. Policies were in place for medicine management,</li> </ul>	



**Medicines management****Y/N/Partial**

such as those which set out the monitoring needed for high risk medicines. Evidence showed these were adhered to.

- We identified 16 patients who had been prescribed warfarin, an anticoagulant medicine used to help prevent blood clots in the blood vessels. We reviewed three patients who had been coded incorrectly and found all had appropriate blood monitoring within the last 56 days, and medicine dosage was reviewed in line with national guidance. The provider had updated their anti-coagulation monitoring protocol after the inspection to ensure there was a system in place for safe care and treatment.
- The practice had a process to manage information changes to a patient's medicines including changes made by other services, for example, the out of hours provider (OOH).
- At the last inspection in March 2021, systems and assurance checks of emergency medicines and equipment were not effective. At this inspection we found, emergency medicines were stored on a crash trolley within the clinical area, accessible to appropriate staff. This had been risk assessed to ensure appropriate medicines were included. There was evidence of regular stock checks including a review of expiry dates. Medical equipment included a defibriliator with adult and child pads were in place.

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Partial
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Y
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	N/A
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	N
<p>Explanation of any answers and other comments on dispensary services:</p> <ul style="list-style-type: none"> <li>• The dispensary service had effective leadership and a designated responsible GP. There was a dispensary lead, who was supported by a dispensary assistant. Staff competencies were reviewed and appraisals conducted annually. The Primary Care Network (PCN) Pharmacist worked at the practice remotely and was on-site on Friday afternoons to assist with delivering patient medicine reviews.</li> <li>• There was a comprehensive standard operating procedure, which covered all aspects of the dispensing process and there was a system in place to monitor staff compliance.</li> <li>• There was an electronic prescribing system that allowed for stock control and automatic ordering when required.</li> <li>• The dispensary had a system to ensure medicine safety in relation to monitored dosage systems and these were audited by both dispensers before issue.</li> <li>• The practice was registered for Dispensing Service Quality Scheme (DSQS). The DSQS is a scheme which rewards practices for providing high quality services to their dispensing patients. As part of the scheme, the dispensary had submitted audit evidence for the Dispensing Review Use of Medicines (DRUM), which reviews usage of patient prescribed medicines, compliance and adherence to national guidance for prescribing.</li> <li>• The practice told us that patient information leaflets for prescriptions had information in braille and large print labels were accessible when required.</li> </ul>	

- Processes were in place for the appropriate storage of medicines that required refrigeration through daily temperature checks. We observed an out of range temperature reading recorded with no actions taken for the fridge at the dispensary. The practice stored vaccines in a separate fridge within one of the clinical rooms. Medicines that were stored in the dispensary fridge only contained skin creams, which guidance in line with manufacturers recommendations stated that these remained safe and effective outside of fridge temperatures for up to one month. The provider raised this as a significant event after the inspection and the report was sent to the inspection team. The learning outcome resulted in a procedure review of the practice's cold chain protocol with updated guidance for staff, including changes to the recording of mandatory actions taken when fridge temperatures exceeded guidelines.
- There were no facilities for dispensers to speak confidentially to patients about their medicines. Staff told us this was due to lack of space at the premises, there was a system for patient telephone call-backs to allow for confidentiality if required.

## Track record on safety and lessons learned and improvements made

### The practice learned and made improvements when things went wrong

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	21
Number of events that required action:	13
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>We were told that significant events were discussed at clinical meetings. We reviewed meeting minutes that demonstrated identified actions were implemented and learning was shared with staff. Staff were clear on their roles to raise safety incidents and how to report concerns appropriately.</li> <li>The practice was able to evidence learning and the dissemination of information relating to significant events. Following a significant event, the practice advised that learning from the event was investigated and discussed at multi-disciplinary team meetings, where formal minutes were recorded and evidenced.</li> </ul>	

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

Event	Specific action taken
An incident occurred where a patient letter was scanned and a task was generated but not actioned.	The incident was reviewed at a clinical meeting which was investigated to find the root cause and learning was shared with staff to minimise the risk of reoccurrence.
Dispensary incident of incorrect information added to repeat prescription	The incident was reviewed openly and transparently. The provider revised the dispensing process and addressed quality assurance checks, minimising the risk of reoccurrence.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>There was a safety alerts policy that outlined the procedure with guidelines for actions to take when receiving alerts. The business manager held the administrative duty to record alerts and share with the dispensary lead on a monthly basis on the actions taken in relation to the alert. We saw evidence of actions taken in response to a recent safety alert.</li> </ul>	

## Effective

## Rating: Good

At our previous inspection in March 2021, the practice was rated Good for providing effective for services.

At this inspection, we rated the practice as Good, we found:

- There were systems in place for monitoring patients with long-term conditions.
- Staff had the skills, knowledge and experience to deliver effective care, support and treatment.
- 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.

*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, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y
Explanation of any answers and additional evidence:	

- GPs referred patients to secondary care and used two-week wait pathways where appropriate. A two week wait pathway is where the cause of a patients presenting condition may be in relation to cancer.
- Vulnerable patients were able to access the service in ways that met their needs during the pandemic.
- Patients were given advice on what to do if their condition deteriorated, for example, call back or contact with the out of hours service. Respective communications between the out of hours service was highlighted when we spoke with senior staff, including the transfer of discharge notifications and changes to patient medication.
- The practice did not always use recognised clinical templates effectively which would have ensured best practice guidelines were always followed. Our remote clinical searches showed that although there was safe care given, the monitoring of clinical care was not always clearly recorded. For example, ten patients were identified as having a potentially missed diagnosis of diabetes. Of the five reviewed, there were shortfalls in coding these correctly. All five of the patients were made aware of their diagnosis at consultation and care plans were in place. The provider told us that there were plans in place for further training for clinicians in this area.

## 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 received a full assessment of their physical, mental and social needs.
- 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 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 assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. The practice told us that they were in the process of recruiting a designated mental health practitioner.
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

- 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.
- 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 shared clear and accurate information with relevant professionals when deciding 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.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with asthma were offered an asthma management plan.
- Medicine reviews for patients with long term conditions were assessed during clinical searches. We identified patients with Chronic Kidney Disease (CKD) stages 4 or 5 had received the appropriate monitoring within the last 18 months, ensuring safe and effective care and treatment.
- We identified nine patients diagnosed with hypothyroidism (a condition where there is low hormone activity of the thyroid gland) who had not had the appropriate monitoring within the last 18 months. Of the five records we reviewed, the practice had acknowledged all of the patients as overdue and had taken steps to address this through recalls. There was a system in place for managing overdue monitoring of patients with long term conditions.

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)	26	27	96.3%	Met 95% WHO based target
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)	35	35	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received	35	35	100.0%	Met 95% WHO based target

Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England)				
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)	34	35	97.1%	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)	35	36	97.2%	Met 95% WHO based target

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

### Any additional evidence or comments

- The practice had met the World Health Organisation (WHO) minimum target of 90% in all five childhood immunisation targets. Clinical staff we spoke to were aware of the practice's initiative to provide further education to assist young families in the importance of these immunisations.
- The practice monitored Did Not Attend (DNA) appointments with appropriate follow-up processes.
- Staff had the appropriate skills and training to carry out reviews for this population group.

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)	83.8%	N/A	80% Target	Met 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (PHE)	74.1%	67.4%	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)	76.7%	69.9%	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)	50.0%	62.3%	55.4%	No statistical variation

### Any additional evidence or comments



- The practice had met the minimum 80% target of eligible patient uptake of cervical screening as well as supporting other early cancer diagnosis.

## 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.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

Any additional evidence or comments
<ul style="list-style-type: none"> <li>At the previous inspection in March 2021, we found the practice had increased their clinical audit activity. At this inspection, the practice continued to develop their clinical audit program and were able to demonstrate quality improvement. For example:</li> </ul> <p>The practice had conducted a two-cycle audit between August 2021 and February 2022 to review whether the appropriate monitoring had been completed for patients who were prescribed Attention-deficit/hyperactivity disorder (ADHD) medicines to ensure patients received safe evidence-based practice.</p> <ul style="list-style-type: none"> <li>Three patients were identified as being prescribed ADHD medicine without the sufficient monitoring, during cycle one. National Institute for Care and Excellence (NICE) guidelines were implemented so that patients had their height, weight, blood pressure or pulse checked in the last 6 months. Cycle two results showed two of the three patients subsequently had received the appropriate monitoring. The third patient had a plan in place.</li> </ul> <p>The practice had conducted a two-cycle audit between January and April 2022 to ensure GPs were recording that minors had been accompanied to appointments and consent to treatment was given to improve record keeping.</p> <ul style="list-style-type: none"> <li>Of the two GPs at the practice, the first cycle results showed 95% and 41% of total consultations that had an adult who had accompanied a minor was recorded. The practice manager discussed performance outcomes with both GPs.</li> <li>Second cycle results showed improvements of 97% and 66% of total consultations that had adult who had accompanied a minor was recorded. The practice told us that they would continue to monitor staff performance, give additional training where needed and re-audit at agreed timescales.</li> </ul>

## 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.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	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.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Staff mandatory training was completed and up to date. There was a system in place to ensure records were checked regularly.</li> <li>• Staff told us they were given protected time to complete training.</li> <li>• We observed records which verified appraisals were conducted with staff, staff performance was monitored and objectives were set. Staff were supported to meet the requirements of professional revalidation.</li> <li>• The nurse manager was able to demonstrate supervision and support for the nursing team through the review of clinical practice and consultation notes.</li> <li>• There was a recruitment policy which outlined the process for new starters. Induction checklists were in place for new staff members for probationary review. Induction guidance was not always available for locum and temporary staff.</li> </ul>	

## 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.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

## Any additional evidence or comments

The practice had a system to manage communication between services about patients so that they received consistent and co-ordinated care. For example, there were daily meetings between the local Out of Hours service and the provider for the safe handover of clinical records and treatment plans of patients moving between the services. The practice used a task management system which allowed medical practitioners in primary care to raise specific clinical tasks with the lead GP outside of the set daily meeting as a safety mechanism.

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The practice had regular engagement and support from the Primary Care Network (PCN) to enhance services for the practice population. For example, a care co-ordinator in the community supported patients aged 75 and over with hospital admission checks. There was a community connector who would assist patients with form filling at the practice.</li> <li>• There was a drive to improve social prescriber links within the PCN, staff told us there were four roles being recruited to. At the time of inspection, we saw evidence of social prescribing schemes for smoking cessation, weight management and physiotherapy self referral.</li> <li>• The practice had received a platinum award by Carers UK for effective provisions for flexible appointments, dedicated carers clinics and a carer support network.</li> <li>• End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.</li> <li>• Same day appointments and longer appointments were offered when required.</li> </ul>	

## Consent to care and treatment

### The practice always was able to demonstrate that it obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y

Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• At the previous inspection in March 2021, the practice had not monitored the process for seeking consent. At this inspection, we found improvements had been made and consent to medical treatment was now part of the practice's audit program.</li> <li>• We reviewed two patients with a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) record to consider whether the DNACPR had been prepared and agreed appropriately. The records were signed and authorised but the latest reviews were outside of the required 12 month date. This revision was discussed with the provider at the time of inspection. RESPECT forms were used for end of life patients where appropriate.</li> </ul>	

## Responsive

## Rating: Good

Cricklade Surgery was rated Good for the provision of responsive services at a previous inspection in September 2016. In accordance with Care Quality Commission's methodology, the rating from our previous inspection for this key question has been carried forward to contribute to the overall rating for the practice.

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) 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 an increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

As such, we have looked specifically at this one aspect of responsive and included in this report. This has not impacted the previous inspection rating for this domain.

### Access to the service

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

	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	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
There were systems in place to monitor the quality of access and make improvements	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>The practice had an online system that allowed patients' remote GP access, to reduce the demand placed on the practice where appointments were at full capacity.</li></ul>	

- Patients had the ability to self-refer through services advertised on the practice website. For example, patients could self-refer to smoking cessation support services.
- The practice utilised links to other healthcare services for patients such as social prescribing. For example, patients could be referred to Age UK to assist with supporting frail individuals at home.
- Feedback received by the Patient Participation Group (PPG) highlighted one of the systems used by the surgery to obtain patient feedback post appointment, in relation to the satisfaction of the appointments offered and the level of care given. The provider monitored the responses and shared performance data with staff on a monthly basis.
- The latest verified NHSE GP patient survey data from August 2021 showed positive trends for patient access against CCG averages.

## Well-led

## Rating: Requires Improvement

At the previous inspection in March 2021, we rated the practice as Requires Improvement for providing well-led services. We found:

- Processes to review policies were not effective as information was not brought up to date following changes in guidance or changes in circumstances.
- Oversight systems were not always effective to ensure compliance. For example, staff training.
- Processes for identifying, managing and mitigating risks did not demonstrate effective oversight.
- Oversight of medicines management processes were not always effective.

At this inspection, we rated the practice as Requires Improvement because systems and processes to ensure good governance were not always effective. However, we did see some good examples of the provision of Well-led services:

- The practice had a clear vision and strategy with effective leadership and culture that put patient care at the priority of its values.
- The practice had improved processes for managing risks, issues and performance.
- The practice had adequate systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic.

### 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.	Y	
They had identified the actions necessary to address these challenges.	Y	
Staff reported that leaders were visible and approachable.	Y	
There was a leadership development programme, including a succession plan.	Y	
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The operations manager was supported by a new business manager who started in April 2021.</li><li>• The practice had a lead GP who was supported by a regular long-term locum. There was a succession plan in place.</li><li>• Staff feedback was obtained formally annually and staff felt that leaders were visible and approachable.</li><li>• After the previous inspection in March 2021, the practice had been working with the Clinical Commissioning Group (CCG) on an action plan that identified areas of requirement to improve the quality and sustainability of the service.</li><li>• Risk assessments had been developed in line with the undertaking of regulated activities, including premises, health and safety and performance. The practice should improve the system for assessing, monitoring and mitigating the risks arising from COVID-19.</li></ul>		

### 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.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• There was a mission statement displayed on the practice website which staff told us they knew about. Staff told us they were proud to work for the practice.</li> <li>• There was a clear business strategy and a set of values developed in collaboration with staff underpinning the overall mission statement.</li> </ul>	

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• There was a system in place in relation to the reporting of incidents with evidence of shared learning and compliance with the duty of candour.</li> <li>• The practice had a whistleblowing procedure available to staff on the intranet. Whistleblowing training was completed by all staff members at the time of this inspection.</li> <li>• The practice had an equality and diversity mandatory training module in place for all staff, which had been completed.</li> <li>• At the previous inspection in March 2021, the practice did not have a formal process to ensure compliance with the duty of candour. At this inspection, we saw evidence that patients were informed when things went wrong and there was a policy in place to give guidance to staff.</li> </ul>	

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

Source	Feedback
3 staff feedback forms	<p>Common themes included:</p> <ul style="list-style-type: none"> <li>• Staff felt supported in their roles by the practice management team.</li> <li>• The culture provided a safe and positive place to work.</li> <li>• There was a strong emphasis on the collaboration to provide high quality patient care</li> </ul>

## Governance arrangements

### The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial

Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was evidence of good governance practice including:</p> <ul style="list-style-type: none"> <li>• Risk management processes being developed as well as management of policies and procedures.</li> <li>• A system to ensure improvement through clinical audit.</li> <li>• A system for safe recruitment which demonstrated full compliance.</li> <li>• An assured safeguarding system in place.</li> </ul> <p>However, governance systems were not always effective. We identified that there were some issues at the inspection not identified and actioned by the practices' own governance systems. For example:</p> <ul style="list-style-type: none"> <li>• Care pathways and protocols evidenced within records for patient medicine reviews were not always followed.</li> <li>• There was evidence found within clinical searches that improvements were required in the coding on patient records to reflect care and treatment received.</li> <li>• The system for monitoring the fridge temperatures needed reviewing to ensure that medicines are being stored in line with the manufacturer's guidance.</li> <li>• Documented risk assessments and procedures relating to patient safety and staff guidance for COVID-19 had not been completed.</li> <li>• Locum packs and guidance for temporary staff was not available.</li> <li>• Not all Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) records had been reviewed within the last 12 months.</li> </ul>	

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<p>At the previous inspection in March 2021, processes for identifying, managing and mitigating risks did not demonstrate effective oversight. For example,</p> <ul style="list-style-type: none"> <li>• Not all risks had received an annual review in line with the relevant assessments, such as the fire risk assessment.</li> <li>• The practice did not have a process for monitoring staff skill mix to ensure that there was appropriate cover for absences.</li> <li>• Medicines management processes were not always effective. Systems to ensure patient group directions (PGDs) were signed and authorised in line with guidance, were not embedded.</li> <li>• The practice could not be assured that held appropriate emergency medicines and equipment.</li> </ul> <p>At this inspection, we found:</p> <ul style="list-style-type: none"> <li>• A quality improvement audit program was in place, which was reviewed by the practice management team.</li> <li>• A business continuity plan was in place which gave guidance to staff for the preparation of major incidents. Impact of care was assessed carefully and involved external stakeholders, for example with Cricklade Town Council to maintain safety of the premises and service under the lease agreement.</li> <li>• There was oversight of staff mandatory training and systems were in place to ensure compliance.</li> <li>• Patient group directions (PGDs) were signed and authorised in line with guidance.</li> <li>• The practice had risk assessed appropriate emergency medicine and equipment. There was oversight of stock control and a system in place to ensure these were checked appropriately.</li> </ul>	

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

	Y/N/Partial
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The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Partial
Staff were supported to work remotely where applicable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice actively managed the quality of access, particularly reviewing the appointment triaging system during the COVID-19 pandemic in order to meet the needs of patients suitably during this time. The practice carried on seeing patients face-to-face during this period and had implemented telephone based consultations to reduce risk to patients who did not necessarily require face-to-face appointments.</li> <li>At the previous inspection, it was highlighted there were no documented risk assessments and procedures relating to patient safety and staff guidance for COVID-19. This had not been completed at this inspection. The practice managers told us that there were processes in place but this had not been documented. Changes had been made to the provision of personal protective equipment (PPE) for staff in light of the pandemic. Remote working was reviewed with staff on an individual basis. The practice should improve the system for assessing, monitoring and mitigating the risks arising from COVID-19.</li> <li>The practice were up to date with the summarising of patient record notes at the time of inspection. There was a system in place to ensure there were no delays to treatment and plans through the management of staff and re-allocation of tasks.</li> </ul>	

## 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.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice had not needed to make any statutory notifications to relevant organisations such as the Care Quality Commission (CQC) or National Health Service England (NHSE) within the last 12 months. However, members of the leadership team were aware of their responsibilities to do so if a notification was required.</li> </ul>	

## 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.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The provider had a registered data controller and data protection officer.</li> <li>Patient data and information was stored securely in line with digital security standards with relevant information was made available for patients to access in line with privacy, consent notices and general data protection regulations.</li> </ul>	

- Information was available for patients on how their data was used, choices regarding consent and how to protect their online data through notices within the practice, practice registration forms or online via the practice website.

## Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The practice had implemented a patient feedback tool through a mobile text messaging questionnaire service which was sent to patients, post-appointment. This had resulted in a high number of responses and reviewed by the practice as a way to improve the service.</li> <li>• Staff were able to give feedback through regular service meetings or at annual appraisals.</li> <li>• The practice worked with the PCN to utilise and share staff resources where required, and Great Western hospital, to offer patient referral pathways which was reflected in the planning of local services and reviewed at stakeholder meetings.</li> </ul>	

## Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> <li>• The practice had engaged and worked closely with the Patient Participation Group (PPG) since the previous CQC inspection in March 2021.</li> <li>• Quarterly newsletters were sent to all PPG members to communicate any changes to the service provision and patient feedback themes. The practice had developed a new PPG questionnaire to capture feedback from members.</li> <li>• Access to clinical care through routine and same day appointment availability was reported as flexible and satisfactory, meeting the needs amongst the practice population.</li> </ul>

## 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.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• We saw examples of meetings minuted which showed the learning outcomes shared in relation to significant events.</li> <li>• The practice showed us documented audits that demonstrated quality improvement amongst clinical staff practice.</li> </ul>	





## 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. 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.
- 
- $\%$  = per thousand.