

Care Quality Commission

Inspection Evidence Table

Cirencester Health Group (1-556469798)

Inspection date: 14 October 2021

Date of data download: 13 September 2021

Overall rating: Good

At our last inspection on 27 November 2019, we rated the service as requires improvement overall. We previously rated the effective and well led key questions as requires improvement and the safe, caring and responsive key questions as good.

A requirement was made under Regulation 17 of the Health and Social Care Act – Good Governance in that the provider had to establish effective systems and processes to ensure good governance in accordance with the regulation.

At this inspection we found the provider had taken action to make improvements and meet the requirement notice.

However, at this inspection we found some areas where the provider needed to make improvements:

- 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 checks and weight.
- There was a backlog in summarising patient records.
- We saw patient confidential and personal information had not consistently been stored securely.

(QOF) data relates to 2019/20.

Safe

Rating: Requires Improvement

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies and procedures were monitored, reviewed and updated.	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
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The safeguarding children's policy and procedure detailed the contact details for external organisations involved in the management of safeguarding concerns. The contact details for the local authority and other relevant organisations was displayed on a notice in the clinical rooms. • Chaperone training was provided for all staff who undertook this role. Staff who had not completed this training confirmed chaperoning was not part of their role and they would not be asked to act as a chaperone. • The practice reviewed the number of attendances of patients at minor injuries units or the emergency department. Information regarding any concerns of this attendance were raised with the patients GP and at the weekly clinical meeting. This meant that any safeguarding concerns linked with this attendance would be identified and action taken promptly. • Staff we spoke with all confirmed they had completed safeguarding training at a level relevant to their role. Staff were knowledgeable about the action they were to take should they identify any safeguarding concerns. For example, one member of staff had reported a safeguarding concern for a young person who had not attended two appointments following discharge from hospital for surgery. The staff used an electronic template to record all relevant information and pass onto the safeguarding lead and the local authority safeguarding team. 	

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
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Explanation of any answers and additional evidence:	

- The practice maintained a recruitment checklist for each new member of staff which detailed information relating to the recruitment checks and procedures. This clearly demonstrated appropriate information was obtained for each applicant.
- We reviewed the personnel records for four members of staff and found the recruitment process had been followed for each person.

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 05/02/2021	Yes
There was a record of equipment calibration. Date of last calibration: 27/11/2020	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
A fire risk assessment had been completed. Date of completion: February 2021	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had obtained the services of an external company to carry out a full and detailed fire risk assessment in February 2020. The practice managers had repeated this assessment in February 2021. • Actions identified in the risk assessment from February 2020 had been addressed. For example, there were trained fire marshals, portable heaters were not located near combustibles and a fire policy was available to all staff. • The practice carried out fire drills so that staff were aware of the action to take should there be a fire in the premises. Fire drills were carried out at both The Avenue and St Peters Road Surgeries. However, the records did not provide evidence that all staff had completed a fire drill within the last year as required by the practice policies and procedures. We raised this with the practice manager who took immediate action and collated detailed records so staff who had not attended were easily identifiable. Two fire drills were arranged (one at each surgery) following the inspection. We were told the fire drills were arranged on different days to accommodate all staff who were required to attend. • Equipment was regularly serviced and calibrated (if necessary). Stickers were attached to the equipment so that staff could easily see the date of the last service and know whether the equipment was safe to use. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out.	Yes

Date of last assessment: 06/07/2021 St Peters Road Surgery and 06/07/2021 The Avenue Surgery	
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 30/09/2021 at St Peters Road Surgery and 21/09/2021 at The Avenue Surgery.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The last premises security risk assessment had identified an issue with an unsecured window. The practice manager told us this had been addressed promptly and all windows and doors secured. We did not see any issues with security during our inspection. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met/not met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 12/08/2021 and 19/08/2021	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Partial
There was a system to notify Public Health England of suspected notifiable diseases.	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. There was an isolation room available for potential COVID-19 patients. The practice had made arrangements for one location to be safe for vulnerable patients and staff to visit during the pandemic and patients with potential symptoms of COVID-19 did not access this location. All clinical staff were responsible for cleaning their consulting rooms between patients, but this was not always recorded. Clinicians confirmed that they carried out this task. The infection prevention and control audit carried out at The Avenue Surgery in August 2021 had identified areas for improvement. For example, not all furniture was cleanable, paintwork in some areas could not be cleaned thoroughly, staff and patient toilets were not separated and hand basins had an overflow and plug which potentially could harbour infection. The infection prevention and control audit carried out at St Peters Road Surgery in August 2021 had identified areas for improvement. For example, not all furniture was cleanable and hand basins had an overflow and plug which potentially could harbour infection. The sinks had not been changed due to the practices plans to move to a new build practice. However, there was no agreed date for this at the time of the inspection. 	

- The practice manager told us they had mitigated the risks by alerting the cleaning staff to pay additional attention to cleaning these areas. The practice managers monitored the cleanliness of the practice and had found no issues with these areas.

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

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.	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"> Summarisation of patient records had a two month backlog which equated to 228 patient records since 30 July 2021. Out of the 228 records 69 had not met the practice's target that the records would be summarised within eight weeks of the patient registering. The records which were longest overdue for summarisation was 30 July 2021. We were told this backlog had occurred due to staff vacancies and sickness over the summer period. As a result, the practice had recruited an additional two administration staff whose role included summarisation of records. The practice had assessed the backlog would take 23 hours of 	

administration time to address and following the recruitment of staff, there was an additional 22 hours a week which was available to be used for summarisation.

- The newly recruited administrators were booked in to attend training for summarising and coding in December.
- The practice had action plan and estimated the eight week target for notes to be summarised would be met by January 2022 with the additional resources.
- If the records of patients were needed prior to being summarised and placed on the system, the administration staff were able to promptly provide this information for clinicians. The practice also prioritized the records of any newly registered patient who had complex needs or for who the GP had identified any concerns.
- We saw paper records for private patients who had attended the practice for surgical procedures, pre 2017, were stored in an unlocked room. We discussed this with the practice and they planned to take immediate action to store these in a secure area.

Appropriate and safe use of medicines

The practice had / did not have 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) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.58	0.68	0.69	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). (01/07/2020 to 30/06/2021) (NHSBSA)	10.3%	10.6%	10.0%	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 (01/01/2021 to 30/06/2021) (NHSBSA)	6.03	5.55	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	138.5‰	127.7‰	126.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	0.68	0.69	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	8.5‰	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.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At this inspection we found the provider had not consistently ensured medicines were prescribed safely on an ongoing basis. We undertook data searches on the clinical record system during the inspection to review the practice's monitoring of patients on specific medicines and the care they required related to taking those medicines. We saw medicine reviews had not been conducted consistently and did not follow a structured process. For example, we reviewed the medical records of five patients and identified that while their records identified a medicines review had been completed, these were not structured and did not consistently ensure risks associated with their medicines had been addressed or discussed with the patients. We found nine patients had not received interventions such as blood tests to ensure they were safe to continue taking specific medicines and at the levels they were being prescribed. Three out of twelve patients prescribed Leflunomide had not had the required monitoring which included blood pressure checks and weight. Leflunomide is an immunosuppressive disease- 	

Medicines management	Y/N/Partial
<p>modifying antirheumatic drug, used in active moderate-to-severe arthritis (a condition that causes pain or inflammation of a joint). The monitoring of patients weight and blood pressure had been impacted by the patient not visiting the practice during the COVID-19 pandemic. We raised this at feedback with the practice post clinical searches which was before our onsite element of our inspection. When we visited onsite, the pharmacists employed by the Primary Care Network (PCN) had taken action to address this issue and were including this monitoring in all future medicine reviews. Reminders had been provided to GPs at the clinical meeting held after our remote searches of the need for structured medicine reviews to identify and address these issues.</p> <ul style="list-style-type: none"> • One patient prescribed an ACE inhibitor or Angiotensin II receptor blocker and Spironolactone together had not received the correct monitoring. These medicines are used to treat congestive heart failure and are not recommended to be prescribed together due to risk of hypotension (low blood pressure), hyperkalaemia (a condition where there is too much potassium in the blood) and impaired renal function. The patient records identified a higher than normal blood test result which had not been repeated. The practice had attempted contact with this patient on two occasions with no success. On the third attempt the pharmacist had discussed the medicines with the patient and arranged for them to have their blood monitored by the community nurses. The patient records did not include the detail of this updated information which meant clinicians would be unclear of the monitoring which had taken place or was due. • One patient prescribed warfarin (a medicine used to thin the blood) was overdue a blood test which was required to determine the dose of warfarin prescribed. Attempts had been made to contact the patient with no response, but the medicine continued to be prescribed. The patient had been admitted to hospital and there were blood results available from the hospital system at the time of their admission. However, the patient records did not provide full detail of the most recent blood result to show the medicine had been prescribed safely. • The practice was made aware of these concerns following the completion of the searches. Between our feedback and the onsite element of our inspection we were provided with evidence which showed action had been taken to contact the patients to arrange for monitoring to be carried out. However, some patients did not wish to attend for routine monitoring such as blood tests. The practice invited the patient by the preferred choice of the patient such as by text messages, letter or telephone call. We saw one patient had booked an appointment and then did not attend. • The practice had also implemented weekly searches for patients prescribed specific medicine which required additional monitoring to be completed. Procedures had been put in place to contact patients to attend for monitoring and detailed whose responsibility this would be. • Policies and procedures had been updated to reflect this change in practice. • The practice had emergency equipment including a defibrillator, oxygen and emergency medicines which were checked weekly and monthly to ensure they were in date and ready for use. 	

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
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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:	10
Number of events that required action:	8

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

Event	Specific action taken
Test results received for patient had not been actioned promptly resulting in a delay in referring the patient to secondary care.	Policy and procedures had been reviewed and developed to guide staff on the action to take. A routine monthly search of tests requested through the electronic system was carried out to ensure results had been reviewed and appropriate action taken.
A medicines error in that the wrong medicine had been administered to a patient.	Learning from the incident was shared among the nursing team and training/reminder on the importance of the review of clinical records given.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We saw examples of action taken following a safety alert. Regarding sodium valproate (A medicine used to treat epilepsy, bipolar disorder and migraine). The practice had ensured women of childbearing age were aware of the risks of sodium valproate in pregnancy. There had been a safety alert regarding the prescribing of Amlodipine and Simvastatin together. Amlodipine is prescribed to treat high blood pressure and Simvastatin to reduce cholesterol levels in the blood. Amlodipine increases the concentration of simvastatin and if no alternative is possible, the recommended maximum daily dose of Simvastatin is 20mg if prescribed with amlodipine. Twenty two patients were prescribed amlodipine and Simvastatin together. The clinical searches identified four of the patients were at risk as there was no documentation regarding discussion and risk assessment for the continuing prescribing of these two medicines together. One patients' medical record identified a medicine review had been carried out by the community nursing team but did not detail what this medicine review had included. This did not ensure the patients' medicines had been reviewed appropriately or relevant discussions about the continuing prescribing of the two medicines had taken place. 	

Effective

Rating: Good

At our previous inspection in November 2019, we rated the practice as Requires Improvement for the effective key question because:

- The practice did not have proper oversight of patients who had been exception reported to ensure reports were accurate.
- Uptake for national screening programmes was below the national target.
- Policies and procedures had not been reviewed in a timely manner.

The practice had engaged with the Care Quality Commission, implementing actions and demonstrating improvements made. Action had been taken to address the above issues identified at the last inspection.

We were mindful that within two months of the last inspection, the COVID-19 pandemic had significantly impacted performance in healthcare delivery with the need to reprioritise aspects of care. There were mitigating factors that made improving uptake challenging. Hard to reach patients needed considerable support and education to engage in healthcare and the COVID-19 pandemic had made this difficult when guidance was to reduce footfall to protect patients and staff.

At this inspection we found that despite potential challenges the provider had continued to make improvements or had plans in place to address deficits.

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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We found gaps in the monitoring of patients on long term and high risk medicines. We discussed this with practice. The practice highlighted the findings in the clinical meeting the week after the remote searches were carried out. As a result, guidelines and processes were reviewed and staff updated on the action they were 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. Annual health checks had been postponed during the COVID-19 pandemic and again due to the current blood bottle shortage. While these issues were out of the control of the practice, it meant patients had not had their ongoing needs fully assessed. The practice had taken action to resume full annual health checks following the lifting of lockdown procedures during the pandemic. During the pandemic staff had assessed and reviewed patients remotely where possible. The practice had achieved a Pride in Practice award. The Pride in Practice programme works with GP practices to ensure that all lesbian, gay, bisexual and trans people have access to inclusive healthcare from providers who understand and meet their needs. 	

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified were referred to an in house 'wellbeing at home' team who provided an assessment of their physical, mental and social needs and signposted to appropriate clinicians and care agencies.
- The practice had been part of a local pilot scheme which had involved identifying frail patients who were socially isolated and proactively contacting them to ensure connection with appropriate support service.
- The practice had access to a social prescriber who provided support to the practice and attended weekly clinical team meetings. Social prescribing enables GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services to support their health and wellbeing.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out annual medicines' reviews for older patients. However, the searches carried out of patient medical records found the practice did not consistently follow a structured format for completing medicine reviews. Therefore, there was a risk important aspects of the review would not be completed. The pharmacists had recognised this and had raised the issue in clinical meetings prior to our onsite visit as part of our inspection. A structured template had been made available within the electronic system. Clinicians had been advised of the use of the template to ensure medicines reviews followed a structured process and included all information required.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

- Health checks, including frailty assessments, were offered to patients over 75 years of age. However, the annual health checks had been temporarily paused during the COVID-19 pandemic and more recently due to the shortage of the supply of blood bottles. The practice regularly reviewed this and had systems in place to invite patients for their health checks once deemed appropriate to do so.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- GPs carried out weekly visits to care homes to meet the health needs of patients living in these settings.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- At the last inspection the practice could not consistently demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. After the last inspection, the practice had reviewed patients who showed indicators of being pre diabetic or were identified as being diabetic. Each patient had been contacted by a GP or the practice diabetes lead nurse to discuss the risks and action required. Appointments were made for the patients to speak to the appropriate clinician. For example, the practice diabetes nurse, GP or community diabetes nurse. The surgery diabetes team met weekly to discuss the care and treatment plans for the identified patients. The practice now used a standardised electronic template a basis for the recall of patients.
- From our remote searches we saw 367 patients displayed indications they may have atrial fibrillation. For 83 of those patients their records did not evidence the risks from stroke had been addressed or appropriate medicines prescribed.
- Patients aged 40-75 were offered annual health checks and appropriate care and treatment was provided for patients identified with ongoing medical requirements. For example, statins were offered to those identified at risk. Statins are a type of medicine that are used to lower the cholesterol in the blood, helping to prevent heart disease and stroke. During the pandemic the annual health checks had been continued by telephone or video consultation and had now resumed with face to face visits following the lifting of the lockdown procedures.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. Longer appointments and home visits were arranged when necessary.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. For example, we saw annual reviews were arranged for patients with asthma, chronic obstructive pulmonary disease and diabetes. During the COVID-19 pandemic, searches had been carried out to identify those patients at higher risk who were encouraged to attend for a review. For patients who lived in care settings, planned visits were arranged to carry out their annual long term condition reviews.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Additional internal training had been provided regarding the electronic templates used to standardise the management of long term conditions.

- 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.
- 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.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	80.0%	77.4%	76.6%	No statistical variation
PCA* rate (number of PCAs).	25.1% (222)	13.5%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	85.4%	92.5%	89.4%	No statistical variation
PCA rate (number of PCAs).	20.5% (53)	14.8%	12.7%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	71.9%	83.0%	82.0%	Tending towards variation (negative)
PCA* rate (number of PCAs).	4.2% (10)	6.6%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	54.5%	68.2%	66.9%	Tending towards variation (negative)
PCA rate (number of PCAs).	6.6% (41)	18.6%	15.3%	N/A

The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	67.6%	73.3%	72.4%	No statistical variation
PCA rate (number of PCAs).	11.5% (169)	8.8%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) <small>(QOF)</small>	95.1%	92.6%	91.8%	No statistical variation
PCA rate (number of PCAs).	4.4% (13)	4.5%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	55.7%	76.7%	75.9%	Variation (negative)
PCA rate (number of PCAs).	7.5% (47)	12.5%	10.4%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Any additional evidence or comments

- 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. However, during the COVID-19 pandemic national guidance was followed to reduce footfall to the practice which had a negative impact on the data seen above. For example, attending the practice for blood pressure monitoring.
- We identified one patient during our remote searches who had high blood pressure recorded. The practice had provided this patient with a blood pressure machine to record their blood pressure at home with a plan for them to gather the results and then be reviewed in the practice. However, it was not clear from their records this had been actioned which left the patient at risk. The practice took immediate action and contacted the patient by telephone to arrange follow up.
- Additional monitoring of patients had taken place since the data provided for personalised care adjustments as detailed above had been published.

Families, children and young people

Population group rating: Good

Findings

- The practice had met the minimum 90% for five of five childhood immunisation uptake indicators. The practice had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of five childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

- Appointments were available outside school hours and urgent triage appointments were available to parents/guardians with acute concerns.
- The practice promoted engagement with younger patients and used online, text and video services.
- The practice safeguarding lead communicated with the health visitor to discuss and safeguarding concerns. Regular monthly meetings encouraged these discussions and included the school nurses where appropriate.
- The practice offered and arranged six to eight week maternal post-natal checks which were combined during the same appointment as the six to eight week baby checks.
- The practice were proactive in identifying young patients and their families who were vulnerable or in disadvantaged situations. An at risk alert was placed on their records and the families were reviewed in weekly clinical team meetings. Appropriate action was taken where necessary.

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) (01/04/2019 to 31/03/2020) (NHS England)	116	121	95.9%	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) (01/04/2019 to 31/03/2020) (NHS England)	109	113	96.5%	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 Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	108	113	95.6%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	109	113	96.5%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	114	125	91.2%	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>

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients normally had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 75. Access to the practice had been reduced during the COVID-19 pandemic in order to follow national guidelines to reduce footfall to the practice. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.
- The practice provided a full range of contraception services included long-acting release contraception and vasectomies.
- Patients could access the practice in a variety of ways such as by telephone, online, video and face to face. This meant that patients could make contact outside of working hours.
- The practice worked together with other practices in their Primary Care Network (PCN) to offer out of hours appointments with nurses and GPs.
- The practice enabled patients who did not live locally but worked in the area of the practice to register and have access to services.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2021) (Public Health England)	74.4%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	67.7%	73.9%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	66.5%	68.0%	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)	95.1%	94.5%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	68.9%	62.6%	54.2%	No statistical variation

Any additional evidence or comments

- The practice had continued to encourage patients to attend the practice for cervical screening during the COVID-19 pandemic.
- Additional clinics had been implemented to provide more appointments for patients to attend for cervical screening.
- An additional practice nurse had completed their cervical screening training with another practice nurse currently in the process of the training. 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. Unpublished data provided during the inspection, while unverified, indicated that the practice was on a trajectory to meet the national target for women aged 25-50 by the end of the reporting year. The unpublished data showed the practice had exceeded the target at 81.1% for women over 50 years.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check. The practice maintained a register to ensure all patients with a learning disability were contacted on or around their birth date to book 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. During the COVID-19 pandemic the practice continued to visit vulnerable patients and those receiving palliative or end of life care, to provide support to the patient and family. Patients were supplied with just in case medicines which meant there was immediate access to medicines to manage symptom control.
- The practice worked closely with the local community nursing team who provided palliative and end of life care to patients at the practice. Communication between the teams was enhanced by the use of the shared patient records in the same electronic clinical record system.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.
- The electronic patient record system alerted staff to patients who required reasonable adjustments to service provision. For example, to support patients with a hearing or sight impairment, language barriers and disabilities.

- Staff had identified challenges faced by patients who lip read due to staff wearing masks during the pandemic. Clear visors / masks had been obtained by the practice for their staff to use and also distributed to care homes and district nursing services to support patients.
- The practice routinely used video conferencing to aid communication with Deaf patients or those with hearing loss. Some members of staff were learning sign language to aid communication.
- The practice had appointed a carer champion at both practices and a register was maintained to identify carers. Additional support and signposting to external organisations was provided by the carer champions, social prescribers and care co-ordinators when needed.
- The care coordinator identified and contacted patients readily discharged from hospital to ensure they did not have any unmet health or social needs.

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

Population group rating: Good

Findings

- The practice offered patients an annual review and assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. The care coordinator carried out reviews for patients identified as living with dementia and liaised with the patients named GP to ensure their care and medical needs were met.
- The training matrix did not evidence that all staff had received dementia training in the last 12 months. However, staff told us that dementia awareness was included in other mandatory training modules.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice were able to signpost patients to external organisations who were available locally for support. Regular communications with the local mental health trust were evidenced and the practice worked within a multi-disciplinary team to provide care and treatment for patients with mental illness.

Mental Health Indicators	Practice	CCG average	England average	England comparison
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The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	89.8%	88.6%	85.4%	No statistical variation
PCA* rate (number of PCAs).	35.2% (32)	22.4%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	88.1%	86.0%	81.4%	No statistical variation
PCA rate (number of PCAs).	15.1% (21)	8.3%	8.0%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Any additional evidence or comments

- Since the publication of the personal care adjustment rates above were published the practice have continued to monitor and review patients. We reviewed four care plans for patients with mental illness and/or dementia and found these had been reviewed and were shared with the patient where appropriate.

Monitoring care and treatment

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

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	525.3	533.9
Overall QOF score (as a percentage of maximum)	94%	95.5%
Overall QOF PCA reporting (all domains)	6.4%	5.9%

	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

- The practice had implemented an electronic system to identify patients who had been admitted to hospital and those readmitted to ensure they were discussed at weekly clinical meetings and followed up appropriately.
- The practice had carried out an initial audit / review of patients on long term Nitrofurantoin (an antibiotic used to treat urinary tract infections) in September 2020. The audit had identified actions for clinicians to take. Following a second audit in September 2021 it was found the number of patients prescribed long term Nitrofurantoin had been significantly reduced.

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 physician 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, signed by the new staff member and their mentor. • Staff who had additional roles / 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 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-centered 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 own 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 was able to demonstrate that it 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
Explanation of any answers and additional evidence:	

- The practice carried out minor surgery at St Peters Road Surgery. We saw the patient records detailed patients were provided with enough information regarding the planned procedure to make an informed choice about the surgery. Written consent was obtained from the patient.

Caring

Rating: Good

Cirencester Health Group was rated Good for the provision of Caring services as a result of our inspection in November 2019. In accordance with Care Quality Commission methodology, the ratings from our previous inspection for this key questions (caring) have been carried through to contribute to the overall rating for the practice.

Responsive

Rating: Good

Cirencester Health Group was rated Good for the provision of Responsive services as a result of our inspection in November 2019. In accordance with Care Quality Commission methodology, the ratings from our previous inspection for this key questions (responsive) have been carried through to contribute to the overall rating for the practice.

Well-led

Rating: Good

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The COVID-19 pandemic had challenged some of the organisational and practice level processes. For example, in relation to patient access and working arrangements for staff. During the pandemic the practice used the two sites as 'green' and 'red' sites. This meant patients attending the practice with potential COVID-19 infection did not meet with vulnerable staff and other patients. • 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. The leadership team were responsive to 	

our feedback and actioned areas promptly which we raised with them. For example, medicine reviews had been undertaken following our remote searches and action taken.

- 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 social care prescriber who provided support to the practice.
- We saw evidence of succession planning. The practice had recruited for 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.
- Leaders were encouraged and supported to complete management training. We were told one member of staff had completed a nationally recognised management training course supported by the practice.

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The vision, values and strategy were shared with all staff. • The practice maintained and regularly reviewed a business plan which highlighted ongoing workstreams, achievements, changes and improvements and any known risks to the practice. We saw the plan had a number of entries that were RAG (red, amber, green) rated so that staff were aware of the assessed priority level of each entry. For example, the workload prioritisation plan following the COVID-19 pandemic was identified as high priority to review all policies and procedures and ensuring all patients with long term conditions were reviewed and followed up appropriately. The practice were able to supply documentation to demonstrate the progress being made. • The business plan was used as a tool for the practice to monitor progress against the delivery of the strategy at the monthly partners meetings. The strategy was reviewed annually. The leadership team had planned to next fully review the strategy in November 2021. In preparation for this review the strategy had been discussed in staff meetings and staff had been issued a survey to gather their views regarding the strategy. 	

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's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
<p>Explanation of any answers and additional evidence:</p> <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 and partners attended staff team meetings. For example, there was a dedicated partner to support the team meetings for 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. 	

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

Source	Feedback
Staff conversations	Staff felt supported in their roles and were able to raise issues or concerns to senior leaders. Staff commented the senior leaders were all approachable and there was good teamwork and communication at the practice. Staff described the practice as a lovely environment to work in and while acknowledging that the COVID-19 pandemic had been challenging and that staff were tired, they had felt supported throughout.

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 who collected clinical waste and the company who provided cleaning services to The Avenue surgery. 	

Managing risks, issues and performance

The practice had 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.	Partial
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	No
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"> The practice had a lone working policy and procedure and staff did not work alone when there were patients in the building. On occasions staff would be lone working when opening or closing the building at the beginning and end of the day. When staff carried out home visits, they provided information of 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 we spoke with knew how to use. Staff reported that on the day of the inspection the alarm had been sounded to summons assistance with a poorly patient being seen by a clinician. Support had been provided promptly due to the swift response of staff in the building. 	

- The practice carried out audits and work projects to review outcomes for patients and took actions 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 providers of services within the practice to ensure systems and processes were effective. For example, the cleaning contractors and the clinical waste collection service.
- The practice had a major incident and business continuity policy and procedure. A cascade system, which staff were familiar with, was in operation to alert all staff in the event of a major incident. However, staff had not received training in the response to a major incident.
- There were areas of risk which had not been monitored or addressed appropriately. For example, there was a backlog of summarisation of patient records and we identified gaps in the monitoring of patients on long term or complex medicines which left them at risk.

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"> • During the COVID-19 pandemic the practice had rearranged services between the registered location, Avenue Surgery and the branch site at St Peters Road Surgery. This had enabled the provision of a 'hot' site to provide care and treatment for patients assessed at risk of having COVID-19 and reduce the risk of cross infection. • 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 pandemic. • In response to the national guidelines changing the practice had adapted their way of working. For example with increased activity in recall of patients for reviews and other screening programmes. 	

- When we inspected, all health services had been informed of a national shortage of blood sample bottles. The practice was required to prioritise urgent testing until the shortage was resolved.
- CQC recognises the ongoing pandemic safety measures and shortages may continue to impact performance data.
- 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
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	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 of each meeting which meant staff who could not attend the meeting had access to the information.• The practice welcomed feedback from staff regarding the planning and delivery of services. For example, staff had identified a streamlined process to manage urine specimens as it had been identified a significant proportion of nurse time was used managing samples. The practice had reviewed and updated the policy and procedure meaning that patients were provided with test forms and sample bottles by the requesting clinician. The patient was then able to drop the sample at the reception which meant the support of nursing staff was not needed.	

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none">• The practice had a Patient Participation Group (PPG) of approximately 13 members who aimed to meet six times a year. We spoke with the chair of the PPG who was positive about the relationship with the practice and said there as an excellent two-way communication channel.• The aim of the PPG was to support the practice, improve the patient experience and run events. For example, the PPG was planning a healthy lifestyles event for 2022 which would provide information to patients on lifestyle choices and improvements.• The PPG sought feedback from a variety of ways. For example, comment cards, face to face meetings at the practice and by telephone.• The PPG had found patients were pleased with the service they received from the practice although at this current time patients voiced they would like to get back to face to face consultations with the clinicians.• The PPG found the practice receptive to feedback and had acted on information shared by patients. For example, the telephone system had been upgraded to provide information on where the patient was in a queue and the prerecorded introductory messages had been changed based on feedback.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff were encouraged to identify actions that would improve the quality of the service provided to patients. We were provided with evidence to support this process. For example, the setting up and running of drive through flu clinics so that an increased number of patients received their flu vaccine during the COVID-19 pandemic with limited close contact. This had proved to be successful and received positive feedback from patients in 2020. The practice had reviewed the process and planned to carry out the same procedure again in 2021. The practice had responded to a national shortage of blood bottles by implementing an electronic waiting list system to ensure patients were contacted in a timely way when cancelling and rebooking appointments. This had been successful and other waiting lists had been created to ensure follow up of patients was actioned within the practice. The practice had amended the system for 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 supply of vaccines. 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.
- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
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- **%₀₀** = per thousand.