

Care Quality Commission

Inspection Evidence Table

Village Surgery (1-543561541)

Inspection date: 25 February 2022

Date of data download: 24 February 2022

Overall rating: Inadequate

At our previous inspection we rated the practice as inadequate overall because:

- The practice did not have sufficient systems and procedures to keep people safe;
- Patients' needs were not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools;
- Staff were not always caring or responsive and patient feedback was not always positive;
- The practice was not sufficiently organised to respond to patients' needs;
- Leaders did not have the capacity or skills to deliver high quality, sustainable care.

At this inspection we have rated the practice as inadequate overall because none of the above concerns had been addressed.

Safe

Rating: Inadequate

At our previous inspection we rated the practice as inadequate for safe because:

- There were insufficient safeguarding systems and practices;
- Staff recruitment processes were unsafe;
- There was insufficient infection control and COVID protocols;
- Medicines were not safely managed.

At this inspection we have rated the practice as inadequate for safe because none of the issues found at the previous inspection had been addressed.

Safety systems and processes

The practice did not have 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.	N1
There was active and appropriate engagement in local safeguarding processes.	Y

Safeguarding	Y/N/Partial
The Out of Hours service was informed of relevant safeguarding information.	N2
There were systems to identify vulnerable patients on record.	N3
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
Explanation of any answers and additional evidence:	
N1 – We found that two clinicians had not completed child safeguarding training.	
N2 – No staff members we spoke with were able to tell us how or if the Out Of Hours service was informed of relevant safeguarding processes.	
N3 - Staff were not sure about the existence of a safeguarding register or list of patients for monitoring or review. The safeguarding lead, a partner at the practice, told us that they were uncertain whether the list included all patients who had safeguarding concerns. The inspection team found that only one patient was coded on the clinical records system with a safeguarding alert. One clinician told us that they were aware of at least six patients who had safeguarding concerns. During the inspection, an administrative staff member showed the inspection team a typed list of patients on an excel document dated the day before the inspection, which they referred to as the safeguarding list. However, there was no evidence of this list being used to monitor, review or discuss the patients it included.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N1
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	N2
Explanation of any answers and additional evidence:	
N1 – We reviewed seven staff recruitment files and found that all of them were missing records for good governance. We saw no evidence of competency checks being undertaken. We saw evidence that some staff had had appraisals and 1:1s carried out. Two recruitment files were missing documents required by Schedule 3 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff 1 did not have an employment history. Staff 2 did not have an employment history, contract, proof of identity, references or Disclosure and Barring Service check.	
N2 - We asked for evidence of staff immunisations and were provided with six records. There were five staff files we reviewed which did not have evidence of immunisations.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: October 2021	N1

There was a fire procedure.	Y
Date of fire risk assessment: None found Actions from fire risk assessment were identified and completed.	N2
Explanation of any answers and additional evidence: N1 - We were given an undated health and safety risk assessment and audit which did not include areas of risk we identified. For example, one of the clinical rooms had a large hole in the ceiling which was not addressed by this risk assessment. After the inspection we were informed that this room was not being used for clinical work due to the hole. N2 – No fire risk assessments were provided after we requested them from staff. We saw no evidence of fire drills being completed by staff.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	N1
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: October 2021	N2
The practice had acted on any issues identified in infection prevention and control audits.	N3
The arrangements for managing waste and clinical specimens kept people safe.	N4
Explanation of any answers and additional evidence: N1 – Two clinical and two non-clinical staff had not completed any infection control training. N2, N3 and N4 - We reviewed the latest Infection Prevention Audit Tool Action Plan dated 1 October 2021 and found the practice had identified 36 problems which had not been addressed. Many of the problems found were Essential Quality Requirements detailed in the Health and Social Care Act 2008 (Hygiene Code). We inspected all four clinical treatment rooms and found the same problems which had been recorded in each room. We found clutter on all surfaces, sharp containers without dates or dated 2019, clinical waste bins overflowing, clinical curtains without dates or dated 2019/2021, cracked walls with peeling paint, no cleaning audits and various clinical items expired such as wipes, needles, aprons, bandages and testing kits. Some of the expired clinical items had expired in 2017.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
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

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
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
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection we found that there was no process for test result management. There was now a documented process for the management of test results and this was managed in a timely manner. For example, on the day of inspection no critical outstanding tests were found and overall, no more than two days of outstanding tests were found.</p>	

Appropriate and safe use of medicines

The practice 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) (01/10/2020 to 30/09/2021) (NHS Business Service Authority - NHSBSA)	0.51	0.60	0.71	Tending towards variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2020 to 30/09/2021) (NHSBSA)	10.8%	10.3%	9.8%	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 (01/04/2021 to 30/09/2021) (NHSBSA)	9.00	5.56	5.32	Significant Variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2021 to 30/09/2021) (NHSBSA)	47.6‰	61.1‰	128.1‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2020 to 30/09/2021) (NHSBSA)	1.36	0.58	0.63	Tending towards variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2021 to 30/09/2021) (NHSBSA)	4.1‰	4.6‰	6.7‰	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.	N1
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N2
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.	N3
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> <p>N1 - During the inspection we carried out a remote records review and identified concerns in relation to patients prescribed high-risk medicines without the required monitoring taking place or without sufficient detail in their monitoring records. Furthermore, there was no protocol for clinicians to follow with guidance as to timelines or details to include in consultation notes.</p> <ul style="list-style-type: none"> • Searches indicated that 58 patients prescribed ACE Inhibitors had not had the required monitoring. Out of the 58 we reviewed five patients who had not had the required monitoring. All five had not had the required monitoring for between four to six years which put patients at risk of harm. • Searches indicated that seven patients prescribed Warfarin had not had the required monitoring. We checked five of these records and found that none of them had had the required monitoring which put patients at risk of harm. • Searches indicated that three patients had been issued more than 12 SABA (Short-Acting Beta-Agonist) inhalers in the last 12 months. We reviewed these records and identified that none of the records provided sufficient information in their medication reviews. 	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> • Searches indicated that out of 73 patients prescribed novel oral anticoagulants (NOACs), 46 patients had not had the required monitoring such as creatinine clearance calculations, urea and electrolyte tests or full blood count checks which put patients at risk of harm. • Searches indicated that two patients prescribed mirabegron had never had blood pressure checks which put patients at risk of harm. <p>N2 - Searches indicated that 277 patients were overdue medication reviews for repeat medicines from 2005 up until the date of this inspection. Out of this number, 46 patients were receiving ten or more repeat medications. As described by the GMC's 'Good Medical Practice', clinicians should ensure that suitable arrangements are in place for monitoring, follow up or review of patients on repeat medications. The lack of follow up, review or monitoring put patients at risk of harm.</p> <p>N3 – The Atropine in the emergency medicines box had expired. The practice immediately ordered this medication to replace it on the day of the inspection.</p>	

Track record on safety and lessons learned and improvements made

The practice did not have a system to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	N1
Staff knew how to identify and report concerns, safety incidents and near misses.	N2
There was a system for recording and acting on significant events.	PARTIAL1
Staff understood how to raise concerns and report incidents both internally and externally.	N3
There was evidence of learning and dissemination of information.	PARTIAL2
Number of events recorded in last 12 months: 6	6
Number of events that required action: 6	6
<p>Explanation of any answers and additional evidence:</p> <p>N1 – We were told that there were no audits of significant events.</p> <p>N2 and N3 - We found a notebook with written communications between the cleaning and reception staff. The notes stated that the front door of the practice had been left unlocked three times in the last six months. Reception staff were aware of these incidents as they had written responses to each note. None of these incidents had been raised as significant incidents. We reviewed the minutes of a clinical meeting dated January 2022 in which a clinician raised concerns regarding a patient's condition. The minutes stated that this event should be recorded as a significant incident. We found no records of this being recorded or investigated as a significant incident.</p> <p>PARTIAL1 – Although there was a file with templates for recording significant events, there was insufficient analysis and recorded outcomes of significant incidents. We reviewed all of the significant incidents records from the last six months, this included six incidents which had occurred between 13</p>	

and 25 October 2021 None of the records included detailed analysis or follow up actions. None of the records included any follow up communication with the patients concerned. All of the records involved the same clinician who had forgotten to follow up concerns with patients or gave patients wrong information. Four of the records had 'discuss in clinical meetings' as the action taken following the incident with no more detail of the resolution or outcome.

PARTIAL2 – Although we did see examples of significant incidents being discussed at clinical and staff meetings, we did not see evidence of learning. For example, nearly all of the recorded incidents related to one clinician, yet that clinician had not completed any additional training, peer reviews or feedback sessions to enable learning or improvement.

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

Event	Specific action taken
Patient urgently needed medication review and diabetic review with blood count.	Discuss in clinical meeting
Patient needed medication Review and Electrocardiogram.	Discuss with the Dr involved in clinical meeting

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	PARTIAL1
Staff understood how to deal with alerts.	PARTIAL2
<p>Explanation of any answers and additional evidence: PARTIAL1 AND 2 – The most recent safety alerts such as Carbimazole had been actioned by clinicians and clinicians were aware of the internal alert system. However, there was no evidence to ensure their electronic patient management system was being updated with this information. This meant that it was not possible for another clinician to easily confirm that alerts had been actioned within the practice by looking through their clinical records.</p>	

Effective

Rating: Inadequate

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.

At our previous comprehensive inspection, the practice was rated as inadequate for providing effective services because:

- Clinical and non-clinical staff had not completed mandatory training;
- Staff had not been having appraisals or competency checks.

At this inspection we rated the provider as inadequate for providing an effective service because:

- Clinicians were not up to date with current evidence-based practice;
- Patients treatment was not regularly reviewed or updated;
- Vulnerable patients had not been prioritised during the pandemic;
- Clinical and non-clinical staff had not completed mandatory training;
- Not all staff had been having regular appraisals or competency checks.

Effective needs assessment, care and treatment

Patients' needs were not assessed, and care and treatment was not 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.	N1
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N2
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.	N3
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	N4
Explanation of any answers and additional evidence: N1 and 2 – Searches indicated that out of 73 patients prescribed novel oral anticoagulants (NOACs), 46 patients had not had the required monitoring such as creatinine clearance calculations, urea and	

electrolyte tests or full blood count checks which put patients at risk of harm. This should have been implemented following current evidence-based practice updates.

N3 – Searches indicated that 277 patients were overdue medication reviews for repeat medicines from 2005 up until the date of this inspection. Out of this number, 46 patients were receiving ten or more repeat medications. As described by the GMC's 'Good Medical Practice', clinicians should ensure that suitable arrangements are in place for monitoring, follow up or review of patients on repeat medications. The lack of follow up, review or monitoring put patients at risk of harm.

N4 – A clinical audit document created by The Village Surgery and sent to CQC on 18 February 2022 set out different lists of patients with long-term conditions who were overdue monitoring, follow up or review. The below patients were put at risk of harm:

- 182 diabetic patients were overdue a foot examination;
- 21 patients with heart failure were over-due a review of functional capacity and medication;
- 91 patients with hypertension were overdue a blood pressure check;
- 266 patients were overdue for cervical screening;
- 581 patients over the age of 65 were overdue a medication review.

Effective care for the practice population

Findings

- Patients did not have access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There were not appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practice did not have a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice could not demonstrate that they had a system to identify people who misused substances.

Management of people with long term conditions

Findings

- Patients with long-term conditions were not offered a structured annual review to check their health and medicines needs were being met.
- Some of the staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs did not follow up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice did not always share clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.

- The practice could not demonstrate how they systematically and consistently identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Patients with suspected hypertension were not always offered ambulatory blood pressure monitoring.
- Patients with asthma were not always offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	44	52	84.6%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	46	51	90.2%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	46	51	90.2%	Met 90% minimum
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)	44	51	86.3%	Below 90% minimum
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)	37	54	68.5%	Below 80% uptake

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

Staff were contacting relevant patients to carry out immunisations where required.

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: 30/06/2021) (Public Health England)	55.2%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (PHE)	49.1%	52.4%	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)	52.7%	63.5%	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)	53.8%	52.8%	55.4%	No statistical variation

Any additional evidence or comments

Staff were in the process of contacting patients to carry out screening.

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

	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.	N
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

N – There were no formal quality improvement audits done at the practice. Although the practice had created a reactionary action plan and a clinical audit following the CQC inspection in September 2021, there was no additional or pro-active work being done to drive improvements outside of regulatory compliance.

Effective staffing

The practice was unable 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.	N1
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.	N2
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.	PARTIAL
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N3
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N4
<p>Explanation of any answers and additional evidence:</p> <p>N1 - We reviewed the staff training matrix and found that eight out of 19 staff members had not completed mandatory training. Two clinicians had not completed basic life support, fire safety or infection control. We were not assured that staff had completed required training to ensure patient safety.</p> <p>N2 – We saw no evidence of staff induction programmes, checklists or records.</p> <p>PARTIAL – Some staff had received appraisals or 1:1s but we found five staff files with no evidence of this.</p> <p>N3 – We saw no evidence of staff competency checks.</p> <p>N4 – One clinician had caused five significant incidents in two weeks (October 13th to 25th 2021) yet they had not been subjected to any performance management, learning and development or given any support. The practice informed us after the inspection that an investigation had been launched.</p>	

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

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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

Consent to care and treatment

The practice was unable 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.	PARTIAL1
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	PARTIAL2
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	PARTIAL3
Explanation of any answers and additional evidence:	
PARTIAL 1, 2 AND 3 – We found one patient with a DNACPR mentioned in their clinical record. However, there was no evidence of the patient's consent, mental capacity or the process that the practice had been through to put this in place for the patient. There was also no alert to ensure clinicians were immediately aware of the patients DNACPR on the clinical system. One clinician told us that they rely on ambulances to inform or alert the practice of DNACPRs.	

Caring

Rating: Inadequate

At our previous comprehensive inspection, the practice was rated as Requires Improvement for providing caring services because:

- the practice was not monitoring, discussing or using patient feedback to drive improvements.

At this inspection we rated the practice as inadequate for providing caring services because:

- the practice was still not monitoring, auditing, discussing or using patient feedback to drive improvements.
- Staff were witnessed during the inspection informing patients that there were no interpretation or language services.
- Staff were witnessed during the inspection ignoring and walking away from a patient at reception.

Kindness, respect and compassion

Staff did not treat patients with kindness, respect and compassion. Feedback from patients was positive and negative about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	N1
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	N2
Explanation of any answers and additional evidence:	
<p>N1 – During the inspection, staff were witnessed telling a Korean patient on the phone that they had to get an English speaker to be able to communicate with the practice. It is well known that New Malden has a large Korean population. The practice is aware of this as the partners and practice manager have mentioned it. No reference was made to the interpretation services available or supposedly used by the practice to enable patients who do not speak English to communicate.</p> <p>N2 – During the inspection, staff were witnessed audibly sighing in a frustrated manner and walking away from a patient at reception who was speaking. The patient asked why staff were walking away and they were being ignored but no staff informed them of the reason. Inspectors interviewed the patient who agreed they had been ignored and they felt the receptionists had been rude.</p>	

Patient feedback	
Source	Feedback
Patient Interview	I have been a patient here for about 20 years. My experience has been good. Some of the reception staff are nice. Sometimes I cannot understand some issues. When the receptionist got up and walked away from me, it was bad. I didn't like that. It wasn't the right thing to do. She walked away from me mid-conversation. Generally they are nice to us.
NHS Choices	There were three, one star reviews and two, five star reviews on NHS choices.

	I have tried getting help from them since august, it has been 5 months and I still haven't gotten the help I need, my appointments keep getting rescheduled, I keep getting sent from one place to another. Do not recommend this GP, I am currently looking to change it.
Google Reviews	There were 56 reviews with an average of 2.4 stars.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	83.5%	90.1%	89.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)	81.8%	88.5%	88.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	90.6%	96.0%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	80.6%	85.2%	83.0%	No statistical variation

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	PARTIAL

Any additional evidence
PARTIAL – Although the practice received text message feedback, none of this feedback was collated, audited or used to implement changes or actions to drive improvements. We saw one staff meeting minutes record where google reviews were discussed with staff.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

Source	Feedback
Interviews with patients.	One patient told us that they generally received good care and treatment from the practice.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	89.8%	93.2%	92.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	N
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: N – During the inspection staff were witnessed telling a Korean patient on the phone that they had to get an English speaker to be able to communicate with the practice. It is well known that New Malden has a large Korean population. The practice is aware of this as the partners and practice manager have mentioned it. No reference was made to the interpretation services available or supposedly used by the practice to enable patients who do not speak English to communicate.	

Carers	Narrative
Percentage and number of carers identified.	28 Carers which is 1% of the practice population.
How the practice supported carers (including young carers).	The practice told us they keep in touch with them and maintain contact with Stay Well, a service which can offer respite.
How the practice supported recently bereaved patients.	The practice told us that they call all patients that are bereaved to offer them support.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive

Rating: Requires Improvement

At our last inspection we rated the practice as Requires Improvement for providing responsive services because:

- not all complaints were responded to, discussed or used to drive improvements.

We rated the practice as requires improvement for providing responsive services at this inspection because:

- not all complaints were responded to, discussed or used to drive improvements.
- Patient feedback and complaints suggested that patient access was a problem at this service.
- Staff were witnessed informing patients that there were no interpretation or language services.

Responding to and meeting people's needs

Services did not meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	N1
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	N2
There were arrangements in place for people who need translation services.	N3
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence: N1, 2 and 3 – During the inspection staff were witnessed telling a Korean patient on the phone that they had to get an English speaker to be able to communicate with the practice.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	08:00 - 18:30
Tuesday	08:00 - 18:30
Wednesday	08:00 - 19:30
Thursday	08:00 - 19:30
Friday	08:00 - 18:30
Appointments available:	
Monday	08:00 - 18:30
Tuesday	08:00 - 18:30

Wednesday	08:00 - 19:30
Thursday	08:00 - 19:30
Friday	08:00 - 18:30

Further information about how the practice is responding to the needs of their population

- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- The practice did not have a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.

Access to the service

People were not able to access care and treatment in a timely way.

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	N1
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	N2
Patients with most urgent needs had their care and treatment prioritised	N
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y

Explanation of any answers and additional evidence:

N1 – There were many complaints about access to this practice made via google reviews, NHS choices reviews, text messages and formal complaints made to the practice in the last six months. There are examples below.

N2 – A clinical audit document created by The Village Surgery and sent to CQC on 18 February 2022 set out different lists of patients with long-term conditions who were overdue monitoring, follow up or review. The below patients were put at risk of harm:

- 182 diabetic patients were overdue a foot examination;
- 21 patients with heart failure were over-due a review of functional capacity and medication;
- 91 patients with hypertension were overdue a blood pressure check;
- 266 patients were overdue for cervical screening;
- 81 patients over the age of 65 were overdue a medication review.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	83.4%	N/A	67.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	76.5%	74.8%	70.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	85.7%	71.4%	67.0%	Variation (positive)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	87.0%	82.1%	81.7%	No statistical variation

Listening and learning from concerns and complaints

Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	Uncertain
Number of complaints we examined.	5
Number of complaints we examined that were satisfactorily handled in a timely way.	1
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	N1
There was evidence that complaints were used to drive continuous improvement.	N2
Explanation of any answers and additional evidence:	

Uncertain – The file for complaints at this practice was disorganised and the inspection team found additional complaints which had not been included. Therefore, it was not possible to know how many complaints had been received in the past year.

N1 - The complaints section of the practice website only had details of how to make complaints via letter to the practice address. The hard copy of the practice's complaint policy provided by one member of staff detailed other avenues patients could use to make complaints including by email. We were told that the website would be updated shortly. We asked four members of staff where the complaint policy was located. Two staff did not know where this was stored. The other staff members provided us with different versions of the practice complaint policy.

N2 – The complaints folder was disorganised and included complaints that had no corresponding response or learning outcome. For example, we saw an email from a patient stating that they accepted an apology from a member of staff that they accused of shouting at them but there was not a copy of the original complaint.

There was a letter of complaint from September 2021 from a social services employee about being unable to access urgent care for a patient they considered at high risk. There was no information linked to the complaint about action taken to resolve the issue.

We also found a copy of one complaint that had no attached response. This complaint had a note attached which stated that on 29/9/21 a member of staff would resolve this complaint. We raised this with the outgoing practice manager who said that they had passed the matter to this doctor, but they had not taken any action and no other action had been taken.

The complaints folder also contained copies of patient records which did not appear to relate to any documented complaint or response contained within the folder. We saw that one complaint was discussed in one clinical meeting on 23 November 2021 but there was no discussion of patient complaints in any prior or subsequent meeting.

We also found two complaints, one dated 2 February 2022 and one dated January 2021 in one of the GP's mailboxes. The GP was not available on the day of our inspection so we raised this with the outgoing practice manager who said that they had not seen either complaint and they would need to speak with the clinician whose mailbox it had been found in. In respect of the complaint dated 2 February 2022, the outgoing practice manager told us this patient had mental health issues which is why it had not been responded to and probably why the doctor had not made the outgoing practice manager aware of it.

Well-led

Rating: Inadequate

At our last inspection we rated the practice as inadequate for providing well-led services because:

- Leaders did not have the skills or capacity to run this practice;
- There was no plan or agreed strategy in place to improve the practice;
- There was a bullying and divisive culture within the staff team at this practice;
- There had been a breakdown in the relationship between the two GP Partners;
- The management team had not completed any audits or reviews of the practice to monitor productivity or consider improvements.

At this inspection we have rated the practice as inadequate for providing well-led services because:

- Leaders still did not have the skills or capacity to run this practice;
- There was still no plan or agreed strategy in place to improve the practice;
- There was a divisive culture within the staff team at this practice;
- The breakdown in the relationship between the two GP Partners had not been resolved;
- The management team had not completed sufficient, effective audits or reviews of the practice to monitor productivity or drive improvements.

Leadership capacity and capability

Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial	
Leaders demonstrated that they understood the challenges to quality and sustainability.	N1	
They had identified the actions necessary to address these challenges.	N2	
Staff reported that leaders were visible and approachable.	N3	
There was a leadership development programme, including a succession plan.	N4	
Explanation of any answers and additional evidence: N1 – The practice manager and the two GP Partners (Leads) had stopped meeting to discuss quality and sustainability for over a year. All three of them told us that they were not speaking to one another and every staff member we spoke with was also aware of the divide in leadership. Neither partner or the practice manager were able to provide any plan to improve this situation. Since the last inspection in September 2021 this problem had not been resolved. Although both partners were now attending clinical meetings, staff told us that these meetings did not enable the practice to drive quality and sustainability. N2 – Since the last inspection in September 2021, none of the leads had identified any actions to address the breakdown in communication at the practice. N3 – Staff members told us that the management team were difficult to approach and communicate with. This included shouting, ignoring or arguing with staff and sometimes clinicians. N4 – There was a divide in the leadership development plan between the two GP Partners and the practice manager. Both Partners had completely different plans for the future of the practice and could		

not agree on either of them. There was a new practice manager training at the time of this inspection, but they were not yet ready to take on full responsibility for managing the practice.

Vision and strategy

The practice did not have a clear vision and it was not supported by a 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.	N1
Staff knew and understood the vision, values and strategy and their role in achieving them.	N2
Progress against delivery of the strategy was monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <p>N1 – There was no realistic strategy to achieve their priorities because none of the leaders within this practice could agree on a business plan.</p> <p>N2 – Staff members we spoke with were aware of the division within the practice and were uncertain about the future of the practice. There were no minutes or records of staff meetings where staff had been informed of any plans or decisions about the practice vision or staff roles in achieving it.</p> <p>Y – There was an action plan created to drive compliance with regulations that the CQC had found breached at the last inspection.</p>	

Culture

The practice culture did not effectively support 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.	N1
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.	N2
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	PARTIAL
<p>Explanation of any answers and additional evidence:</p>	

N1 – Staff told us that they were unable to communicate concerns with some of the leaders of this practice.

N2 – We were told that meeting minutes were edited in order to cover up concerns regarding certain clinicians.

PARTIAL – We found that six staff members had not completed or updated their equality and diversity training. This included the practice manager.

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

Source	Feedback
Staff	We were told that the breakdown in communication between the management team had created split practice with a tense atmosphere that staff did not enjoy.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N1
Staff were clear about their roles and responsibilities.	N2
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<p>N1 – None of the governance systems were effectively reviewed by the practice manager. Although there was an action plan to improve governance systems, this plan had been in place for six months and insufficient improvements had been made to create audits of various areas of records. For example, there were still no audits of complaints, significant incidents, safeguarding, patient surveys/feedback, cleaning and fire safety.</p> <p>N2 – Throughout this inspection the practice manager struggled to find documents and records because it was not clear whose responsibility it was to manage the records or the actions. Upon arrival at the practice we found that there was a trainee practice manager in the office who was uncertain of whether they were responsible for managing the practice that day. The trainee manager told us that their contract for employment set the start date as 1 March 2022. The trainee manager told us that they were at the practice to complete training which they had been doing since 22 February 2022. Staff told us that the actual practice manager did not work on Fridays. Two reception staff told us that the trainee manager was the responsible staff member for the day. When reception staff encountered a problem with a patient on the phone who did not speak English, they asked the trainee manager to assist them. We were not assured that staff clearly understood or knew internal roles and responsibilities.</p> <p>We found policies which named staff members as leads but when asked, staff told us that other staff members were leads. This was the case for safeguarding and COVID policies and protocols.</p>	

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N1
There were processes to manage performance.	PARTIAL1
There was a quality improvement programme in place.	PARTIAL2
There were effective arrangements for identifying, managing and mitigating risks.	N3
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
<p>Explanation of any answers and additional evidence:</p> <p>N1 – There were insufficient assurance systems which were reviewed or improved at this practice. For example, there were still no audits of complaints, significant incidents, safeguarding, patient surveys/feedback, cleaning and fire safety.</p> <p>PARTIAL1 – Some staff had received appraisals or 1:1s but we found five staff files with no evidence of this.</p> <p>PARTIAL2 – There was a quality improvement programme implemented at this service following the last inspection in September 2021. Some areas of concern which required work had been addressed. For example, the majority of staff had completed mandatory training at this inspection. However, there were still many areas of concern which had not been addressed, for example; staff competencies had not been completed for any staff members.</p> <p>N3 – There was a risk assessment of the premises, but it had not identified, managed or mitigated risks found at the inspection. For example, there was a large hole in the ceiling of one of the treatment rooms and multiple clinical equipment items expired in all treatment rooms. After the inspection we were informed that this room was not being used for clinical work due to the hole.</p>	

The practice had some 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.	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.	N1
There were recovery plans in place to manage backlogs of activity and delays to treatment.	N2
Changes had been made to infection control arrangements to protect staff and patients using the service.	N3
Staff were supported to work remotely where applicable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>N1 – Although the practice had a system in place to request feedback via text message, it was not being monitored or used to improve processes. We found multiple complaints within this system which related to access. The practice had not reviewed, considered or responded to these.</p> <p>N2 – Clinical audits and clinical records searches showed that hundreds of patients were backlogged and delayed for monitoring and treatment. This was found at the last inspection in September 2021. In the six months since the last inspection, the practice had not managed to effectively plan or organize the service to adequately address or ensure the safety of these patient lists.</p> <p>N3 - We asked to see evidence of staff asymptomatic testing for COVID and were given a handwritten document which was unclear and disorganised. The majority of notes stated “In their email/mobile” without any sign of the test result or date. Other entries were X’s or ticks without any explanation or index to set out their meaning. There were gaps in some weeks for staff members who were not recorded as having done any tests.</p> <p>We observed staff not wearing PPE or removing PPE when speaking to patients. We were not assured that COVID policies and guidance were being safely followed or monitored.</p>	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	N1
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Y – Staff were now using data to monitor and improve performance.</p> <p>N1 – There were no records competency checks to hold staff or management to account. Some staff had received appraisals or 1:1s but we found five staff files with no evidence of this. We reviewed all of the significant incidents records from the last six months, this included six incidents which had occurred between 13 and 25 October 2021. Most of the records involved the same clinician who had forgotten to follow up concerns with patients or gave patients wrong information. There was no evidence that the clinician had been held to account for the errors. The practice informed us after the inspection that an investigation had been launched.</p>	

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

Engagement with patients, the public, staff and external partners

The practice did not involve 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.	N
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: N – Although the practice was receiving text messages, NHS Choices and Google Reviews as feedback, there was no evidence that any improvements had been implemented as a result. No NHS Choices or Google Reviews had been responded to online by the practice.	

Feedback from Patient Participation Group.

Feedback
The minutes from the meeting dated 5 October 2021 suggested that all four participating patients were very happy with the service they have received.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	N1
Learning was shared effectively and used to make improvements.	N2
<p>Explanation of any answers and additional evidence:</p> <p>N1 – The practice’s approach to learning and improvement was reactionary and limited to where the CQC had previously found concerns at the last inspection in September 2021. As insufficient improvements had been made throughout the governance of this practice, it is not possible to find that continuous learning or improvement is a focus at this practice.</p> <p>N2 – There were some staff and clinical meeting minutes where concerns, complaints and incidents had been discussed. However, there was no evidence of consequent improvements or learning being implemented as a result of the meetings.</p>	

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a “z-score” (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices 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.
-
- ‰ = per thousand.