

Care Quality Commission

Inspection Evidence Table

Stonecross and West Drive Surgery (1-541837584)

Inspection date: 5 August 2022

Date of data download: 01 August 2022

Overall rating: Not rated

The practice was not rated as a result of this inspection. Our findings were as follows:

- Improvements to the practice's systems, practices and processes were insufficient and did not always keep people safe and safeguarded from abuse.
- Improvements to systems and processes to help maintain appropriate standards of cleanliness and hygiene were insufficient.
- Improvements to the assessment, monitoring and management of risks to patients, staff and visitors were insufficient.
- Improvements to the arrangements for managing medicines were insufficient and placed patients at continued risk of harm.
- Systems for dealing with safety alerts were still not always effective.
- Patients' needs were still not always assessed, and care as well as treatment were not always delivered in line with current legislation, standards and evidence-based guidance.
- There was still not an effective programme of quality improvement activity that routinely reviewed the effectiveness and appropriateness of the care provided.
- Staff had the skills, knowledge and experience to carry out their roles. However, not all staff were up to date with essential training and not all staff had access to regular appraisals.
- Staff were still not always consistent and proactive in helping patients to live healthier lives.
- Patients were still not always given appropriate and timely information to cope emotionally with their care, treatment or condition.
- National GP patient survey results published in July 2022 demonstrated a deterioration in all patient satisfaction scores relating to care and treatment delivered by this practice.
- Staff continued to not always communicate with patients in a way that helped them to understand their care, treatment and condition, and any advice given.
- The practice organised and delivered services but these continued to not always meet patients' needs.
- People were still not always able to access care and treatment in a timely manner as insufficient nursing staff were employed in order to meet patients' needs.
- National GP patient survey results published in July 2022 demonstrated a deterioration in all patient satisfaction scores relating to access at this practice.
- Leaders had not taken sufficient action on all required improvements to quality, safety and performance which placed patients at continued risk of harm.
- The practice had a vision to deliver high quality care and promote good outcomes for patients. However, they were continuing to fail to meet this vision.
- Improvements to processes for managing risks, issues and performance were still insufficient.
- The provider had systems to continue to deliver services, respond to risk and meet patients' needs during the pandemic. However, these were still not always effective.

- The practice did not always act on appropriate and accurate information. Quality and operational information were still not always being used effectively to help monitor and improve performance.
- The practice did not always involve the public, staff and external partners to help ensure they delivered high-quality and sustainable care. Improvements were still required.

Safe

Rating: Not Rated

The practice was not rated as a result of this inspection. Our findings were as follows:

- Improvements to the practice's systems, practices and processes were insufficient and did not always keep people safe and safeguarded from abuse.
- Improvements to systems and processes to help maintain appropriate standards of cleanliness and hygiene were insufficient.
- Improvements to the assessment, monitoring and management of risks to patients, staff and visitors were insufficient.
- Improvements to the arrangements for managing medicines were insufficient and placed patients at continued risk of harm.
- Systems for dealing with safety alerts were still not always effective.

Safety systems and processes

Improvements to the practice's systems, practices and processes were insufficient and did not always keep people safe and safeguarded from abuse.

Safeguarding	
Policies and other documents covering adult and child safeguarding were accessible to all staff. They clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare.	Yes
GPs and staff were trained to appropriate levels for their role and knew how to identify and report concerns.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial
Additional evidence or comments	
<p>At our inspection in April 2022 we found the practice's vulnerable adults policy contained minimal information to guide staff if they had concerns about a patient's welfare. The document named the GP partner who was the safeguarding lead but did not detail other staff's responsibilities in relation to safeguarding vulnerable adults nor staff training requirements. The document did not contain contact details of local safeguarding authorities. However, these contact details (including telephone numbers) were displayed on posters in the practice.</p> <p>During our inspection in August 2022 we found the provider had updated their safeguarding policies. However, they did not contain a planned review date so we could not be sure there were plans to keep them up to date in the future.</p> <p>At our inspection in April 2022 we asked to see the safeguarding training records of six members of staff. We were not provided with the safeguarding training records of one member of clinical staff so we could not be sure they were up to date with this training. Safeguarding training records we were sent showed one member of clinical staff had not been trained to the appropriate level.</p> <p>During our inspection in August 2022 we found records showed the member of clinical staff, for whom</p>	

Safeguarding

we were not provided with evidence of their safeguarding training, was up to date with this training. The other member of staff who had not been trained to the appropriate level in safeguarding had left the practice.

At our inspection in April 2022 we asked to see the Disclosure and Barring Service (DBS) check records of six members of staff. We were not provided with the DBS check records of one member of clinical staff so we could not be sure one had been undertaken to help ensure they were suitable to be employed at the practice.

During our inspection in August 2022 we found records showed the member of clinical staff, for whom we were not provided with evidence of their DBS check, had a criminal conviction recorded on it. We asked to see evidence that the provider had carried out a risk assessment of employing this member of clinical staff with a criminal conviction on their DBS check. However, we were not provided with any evidence such a risk assessment had been carried out. The provider was unable to demonstrate they had assessed or considered whether there was any risk to patients from employing this member of clinical staff.

At our inspection in April 2022 we found the practice's computer system alerted staff of children that were on the risk register. However, we looked at the records of four such children and found that the practice's computer system did not alert staff to all family and other household members of these children.

During our inspection in August 2022 we found the practice's computer system still alerted staff of children that were on the risk register. However, we looked at the records of nine such children and found that the practice's computer system did not alert staff to all family and other household members of these children.

Recruitment systems

Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
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Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
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There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
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Additional evidence or comments

At our inspection in April 2022 we asked to see the photographic identification and reference records of six members of staff. We were not provided with these for one member of clinical staff so we could not be sure that recruitment checks for this member of staff had been carried out in accordance with regulations.

During our inspection in August 2022 we saw records that confirmed relevant recruitment checks had been carried out for the member of clinical staff for whom we were not provided with evidence of photographic identification and reference records.

At our inspection in April 2022 we asked to see the hepatitis B vaccination status records of four members of staff. We were not provided with these for one member of clinical staff so we could not be sure that their vaccination was maintained in line with current PHE guidance relevant to their role.

During our inspection in August 2022 we saw records that confirmed the hepatitis B vaccination status of the member of clinical staff for whom we were not provided these records.

At our inspection in April 2022 we asked to see the registration with their relevant professional organisation records of three members of clinical staff. We were not provided with these for one member of clinical staff so we could not be sure they were being checked or regularly monitored.

During our inspection in August 2022 we saw records that confirmed the member of staff for whom we were not provided these records was registered with their relevant professional organisation.

Safety systems and records	
There were up to date fire risk assessments that incorporated an action plan to address issues identified.	Partial
The practice had designated fire marshals.	Yes
Staff were up to date with fire safety training.	No
Additional evidence or comments	
<p>At our inspection in August 2021 we found there was not a review of fire safety risks. The most recent fire risk assessment report for Stonecross Surgery was dated 2015 and a fire safety visit had been carried out by the local fire service in 2019. Staff told us a more recent fire risk assessment had been carried out and the report was pending. At West Drive Surgery there was a fire risk assessment report dated August 2019. Action included the recommended replacement of emergency lighting within six months and this had not been completed. A further recommendation that there were monthly checks of emergency lighting had not been actioned. Weekly testing of the fire alarm system had been identified as an action, but this had been carried out monthly.</p> <p>At our inspection in April 2022 we found a fire risk assessment had been carried out at Stonecross Surgery on 4 August 2021 that incorporated an action plan to address issues identified. The action plan contained a timeline for when actions were to be completed. For example, improvements to fire safety record keeping were required to be completed within one month. Records showed two actions had not yet been completed.</p> <p>Improvements to fire resistant doors were to be completed within three months of the risk assessment being carried out. Records showed the appointed repairer had been unable to carry out the required improvements as scheduled. However, other records showed this work was booked to be completed on 8 April 2022.</p> <p>Overloading of power sockets was to be addressed within three months of the risk assessment being carried out. Records showed that some action had been taken to address this issue. However, this had not been fully addressed in a timely manner as during our inspection we found power sockets were still being overloaded. For example, in one of the non-clinical rooms we found three electrical devices were plugged into one extension lead. This extension lead was plugged into another extension lead that, in turn, was plugged into a wall socket. The electrical wires for these extension leads, as well as other electrical wires from other devices, were trailing across the floor and represented a trip hazard.</p> <p>We found doors marked 'fire door keep locked and shut' at Stonecross Surgery were not kept locked. For example, the door to the isolator cupboard, which was accessible to patients and visitors, as well as the door to the loft void on the first floor of the building. This had not been identified by the fire risk</p>	

assessment. We told staff about this, but no action was taken to lock these doors during our inspection.

We found doors marked 'fire door keep shut' were wedged open at Stonecross Surgery. For example, doors to the treatment room, the staff kitchen and the business manager's office. This had not been identified by the fire risk assessment. We told staff about this. Action was taken and most doors marked 'fire door keep shut' were closed. However, the door to the treatment room remained wedged open for the duration of our inspection.

During our inspection in August 2022 we found improvements to fire resistant doors at Stonecross Surgery had still not been carried out. Staff told us the GP partners did not want to pay for the improvements as they were planning to hand their General Medical Services (GMS) contract over to a new provider in the near future. They told us the GP partners wanted the new provider to bear the cost of the required improvements.

We also found overloading of power sockets had still not been fully addressed. For example, in one of the non-clinical rooms we found three electrical devices were plugged into one extension lead. This extension lead was plugged into another extension lead that, in turn, was plugged into a wall socket. The electrical wires for these extension leads, as well as other electrical wires from other devices, were trailing across the floor and represented a trip hazard.

We also found the door to the isolator cupboard marked 'fire door keep locked and shut' was now kept locked and shut. However, we found the door to the loft void on the first floor of the building marked 'fire door keep locked and shut' was still not kept locked.

We found that all doors marked 'fire door keep shut' were no longer wedged open and were kept shut.

At our inspection in April 2022 we saw a fire risk assessment had been carried out at West Drive Surgery on 4 August 2021 that incorporated an action plan to address issues identified. Records showed all but one action had been completed. Improvements to fire resistant doors were to be completed within three months of the risk assessment being carried out. Records showed that the appointed repairer had been unable to carry out the required improvements as scheduled. However, other records showed that this work was booked to be completed on 8 April 2022.

During our inspection in August 2022 we found improvements to fire resistant doors at West Drive Surgery had still not been carried out. Staff told us the GP partners did not want to pay for the improvements as they were planning to hand their General Medical Services (GMS) contract over to a new provider in the near future. They told us the GP partners wanted the new provider to bear the cost of the required improvements.

At our inspection in April 2022 staff told us there were two fire marshals, one that worked at West Drive Surgery and another that worked at Stonecross Surgery on Tuesday and Friday 2.30pm to 6.30pm and the rest of the time at West Drive Surgery. This meant there was no fire marshal on duty at Stonecross Surgery on Monday, Wednesday and Thursday or on Tuesday and Friday from 8am to 2.30pm. During our inspection we pointed this out to the provider who arranged for another member of staff to be appointed as an additional fire marshal at Stonecross Surgery to cover the period when no fire marshal was on duty there. However, this newly appointed fire marshal as well as one of the existing fire marshals had not received fire marshal training. Records showed the existing fire marshal that had not received relevant training was on a waiting list for fire marshal training. However, there was not a planned date by which this training was to take place.

During our inspection in August 2022 we found there were sufficient trained fire marshals on duty at Stonecross Surgery and West Drive Surgery at all times when the practice was open.

At our inspection in April 2022 we asked to see the fire safety training records of six members of staff. We were not provided with these records for two members of staff so we could not be sure they were up to date with this training.

During our inspection in August 2022 we saw records that confirmed the two members of staff for whom we were not provided with evidence of their fire safety training had received this training in July 2021. However, as this training was only valid for 12 months they were now not up to date with fire safety training.

After our inspection the provider wrote to us with evidence to show one of these members of staff updated their fire safety training on 7 August 2022.

Infection prevention and control

Improvements to systems and processes to help maintain appropriate standards of cleanliness and hygiene were insufficient.

There was an up to date infection prevention and control audit that incorporated an action plan to address issues identified.	No
Relevant staff were up to date with infection prevention and control training.	No
Additional evidence or comments	
<p>At our inspection in August 2021 we found no infection prevention and control (IPC) audit had been carried out in 2020. An IPC audit had been conducted in July 2021, but this failed to identify all IPC risks and did not contain a clear action plan to address issues that were identified.</p>	
<p>At our inspection in April 2022 we found one infection prevention and control (IPC) audit had been carried out on 11 November 2021 that covered Stonecross Surgery and West Drive Surgery. The audit incorporated an action plan to address issues identified. However, the audit was incomplete as six of the questions contained in the audit did not have an answer recorded against them. For example, is there a programme for carpet, curtain and blind cleaning? The action plan contained a timeline by when planned action was to be taken. However, records did not always indicate if the planned action had been completed. For example, the immunisation status of all staff was to be obtained within three months of the audit but there were no records to confirm this had been completed.</p>	
<p>Some information captured in the IPC audit was incorrect. For example, the answer to the question have all clinical staff received annual IPC training was recorded as yes. Records showed one member of clinical staff had last received IPC training in January 2020 and was therefore not up to date with this training at the time of the audit.</p>	
<p>We saw metal radiator covers in the two patient toilets located in the reception area of Stonecross Surgery were rusty. This meant cleaning would not always be effective. This had not been identified by the IPC audit.</p>	

We found pull cords used to operate the light and the extractor fan in one of the toilets at Stonecross Surgery were dirty and not able to be cleaned. We found the same issues in two toilets at West Drive Surgery. These represented a source of infection to anyone that used them. This had not been identified by the IPC audit.

After our inspection the provider wrote to us with evidence to show the IPC audit document had been updated in April 2022. However, the audit was still incomplete as five of the questions contained in the audit did not have an answer recorded against them. For example, is the offensive and infectious waste bin in good condition? The updated IPC audit also failed to identify the two rusty radiator covers in the two patient toilets located in the reception area of Stonecross Surgery nor the dirty pullcords that operated lights and an extractor fan.

Disposable curtains were in use in the nurse's room at West Drive Surgery. However, they were not dated so we could not be sure how long they had been in use.

During our inspection in August 2022 records showed a further IPC audit of both Stonecross and West Drive Surgeries had been completed on 4 July 2022. The audit identified IPC risks that required addressing by the provider. For example, all clinical areas were not being decontaminated at the beginning and end of each clinic and there was no chlorine releasing agents available for spillages of blood. However, staff told us an action plan to address issues identified by the audit had not yet been developed.

Staff told us the rusty radiator covers in the two patient toilets located in the reception area of Stonecross Surgery had been repainted. We looked and saw this was correct. However, we saw rust was still present on the metal radiator cover in the men's toilet. This meant cleaning would still not always be effective and had not been identified by the IPC audit carried out on 4 July 2022.

We found pull cords used to operate the light and the extractor fan in one of the toilets at Stonecross Surgery had been replaced with new ones that were fitted with covers that could be easily cleaned.

At our inspection in April 2022 we asked to see the IPC training records of four members of clinical staff. We were not provided with these records for one member of clinical staff so we could not be sure they were up to date with this training. Records showed that another member of clinical staff last received IPC training in January 2020 and was, therefore, not up to date with this training. After our inspection the provider wrote to us with evidence to show this member of staff had completed IPC training on 7 April 2022 and was up to date.

During our inspection in August 2022 we saw records that confirmed the clinical member of staff for whom we were not provided with evidence of their IPC training had received this training in July 2021. However, as this training was only valid for 12 months they were now not up to date with IPC training.

Risks to patients, staff and visitors

Improvements to the assessment, monitoring and management of risks to patients, staff and visitors were insufficient.

There was an effective approach to managing staff absences and busy periods.	No
All staff were up to date with basic life support training.	Yes

There was written guidance for staff to follow to help them identify and manage deteriorating or acutely unwell patients.	Yes
Staff were up to date with training in how to identify and manage patients with severe infections. For example, sepsis.	Yes
There were a variety of health and safety risk assessments that incorporated action plans to address issues identified.	Partial
There was an up to date legionella risk assessment and an action plan to address issues identified.	No

Additional evidence or comments

At our inspection in April 2022 we found insufficient nursing staff were employed in order to meet patients' needs. The practice employed one nurse who worked at Stonecross Surgery one day each week and West Drive Surgery one day each week. A locum nurse was also employed directly at the practice. We asked for details of this nurse's whole time equivalent (WTE) and pattern of weekly work but were not provided with this information. At the time of our inspection the next available appointment with a nurse was 5 May 2022.

After our inspection the provider wrote to us and told us the locum nurse worked at Stonecross Surgery 9am to 2.30pm three Fridays each month and at West Drive Surgery 9am to 1pm one Monday each month. However, this additional information failed to demonstrate that sufficient nursing staff were employed in order to meet patients' needs.

Staff told us that additional nursing staff were being recruited as the practice was unable to provide sufficient appointments to administer childhood immunisations or carry out cervical screening.

During our inspection in August 2022 staff told us the practice nurse was no longer working for the practice. They also told us that one of the healthcare assistant's (HCA) was no longer working for the practice and the other HCA would be leaving in the near future. This meant once the second HCA had left the practice there would be no HCAs employed to help meet patients' needs.

Staff told us that a locum practice nurse was now being employed one day per week and a practice nurse had been recruited and was employed three days per week. Although this demonstrated an increase in the number of practice nurses currently being employed we were not provided with any evidence of the impact of this increase (nor of the loss of the HCA) on patient care.

At our inspection in April 2022 we asked to see the basic life support training records of six members of staff. We were not provided with these records for one member of clinical staff so we could not be sure that they had received this training. After our inspection the provider wrote to us with evidence to show that this member of staff had attended basic life support training on 15 March 2022. Records showed that another member of clinical staff last received basic life support training in July 2018 and was, therefore, not up to date with this training. After our inspection the provider wrote to us with evidence to show that this member of staff had completed online adult basic life support training in February 2022. However, we were not provided with any records to show that they had received any paediatric basic life support training since July 2018. Records also showed that another member of clinical staff had received adult basic life support training in December 2020 and was, therefore, not up to date with this training. We were also not provided with any evidence to show that this member of staff had received paediatric basic life support so we could not be sure they were up to date with this training. Records showed that other staff had completed online basic life support training. Staff told us that an external company was booked to deliver basic life support training to all staff on 7 April 2022 and records confirmed this.

During our inspection in August 2022 staff told us the member of clinical staff for whom there was no evidence that they had received paediatric basic life support training since July 2018 was no longer working at the practice. Records showed that the other member of clinical staff for whom there was no evidence that they were up to date with basic life support training had now attended this essential training.

At our inspection in April 2022 we found there was written guidance for staff to follow to help them identify and manage patients with severe infections. For example, the sepsis policy. However, this document was not dated and only provided such guidance on the identification and management of patients over the age of 12 years. There was, therefore, a risk that staff might fail to identify and manage children under that age of 12 years with severe infections such as sepsis.

During our inspection in August 2022 we saw this policy had been reviewed as well as updated in July 2022 and now contained guidance for staff on the identification and management of all patients including those under the age of 12 years. However, the policy did not contain a review date so we could not be sure it would be kept up to date.

At our inspection in April 2022 we asked to see the recognition and management of patients with severe infections such as sepsis training records of six members of staff. We were not provided with these records for one member of clinical staff so we could not be sure they were up to date with this training.

During our inspection in August 2022 records showed the member of clinical staff for whom there was no evidence that they were up to date with recognition and management of patients with severe infections such as sepsis training had attended this essential training.

At our inspection in April 2022 we found a cupboard containing patient records was accessible to patients and visitors at Stonecross Surgery. For example, letters referring patients to other services. We told staff about this, but they were unable to lock the cupboard as they were unable to locate the relevant key.

After our inspection the provider sent us evidence to show a new lock for installation in this cupboard was ordered on 5 April 2022.

During our inspection in August 2022 we found the cupboard that contained patient records that was accessible to patients and visitors at Stonecross Surgery was now kept locked.

At our inspection in August 2021 we found, although a security and premises risk assessment had been carried out, an overarching health and safety risk assessment had not been conducted and there was no proactive process to identify health and safety risks.

At our inspection in April 2022 we asked to see the latest health and safety risk assessments for both Stonecross and West Drive Surgery.

We were given a document entitled HS Risk Assessment Monthly Walk Around for Stonecross Surgery. This document contained a list of things that were observed during the walk arounds as well as the dates the walk arounds took place. For example, carpets and flooring, workstations as well as pedal bins. It also contained some detail of action taken. For example, chair replaced in clinical room and bulb changed in the car park. However, it did not constitute a formal health and safety risk assessment. Staff told us a formal risk assessment was scheduled to be carried out by an external

company on 14 April 2022 and records confirmed this.

A health and safety risk assessment had been carried out at West Drive Surgery on 12 July 2021 that incorporated an action plan to address issues identified. However, the action plan for one of the issues identified did not adequately address it. The risk assessment recorded it was not always practicable for staff to log out at all times if leaving their workstation and that they were aware of the consequences. We looked but could not find further evidence of planned action to ensure compliance with logging out at all times when leaving their workstation.

During our inspection in August 2022 records showed health and safety risks assessments had been carried out at Stone Cross Surgery and West Drive Surgery on 14 April 2022. Both risk assessments incorporated action plans to address issues identified. However, there was no timeline recorded on the action plan to address issues identified at Stonecross Surgery.

At our inspection in April 2022 we found legionella risk assessments had been carried out at Stonecross Surgery on 10 February 2022 and at West Drive Surgery on 8 February 2022. Both contained recommendations to address issues identified. However, staff told us action plans, including timescales for completion of works, had not yet been formulated.

Water samples had been sent and results dated 3 February 2022 showed legionella had not colonised the building's water system at West Drive Surgery. However, staff told us that water samples had not yet been sent from Stonecross Surgery.

During our inspection in August 2022 staff told us action plans to address issues identified by the legionella risk assessments carried out in February 2022 were being outsourced to an external organisation for completion. However, this had not yet been carried out.

Other records showed water samples had been sent and results dated 3 May 2022 showed legionella had not colonised the building's water system at Stonecross Surgery.

Appropriate and safe use of medicines

Improvements to the arrangements for managing medicines were insufficient and did not always keep patients safe.

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) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	1.10	0.83	0.79	Tending towards variation (negative)
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). (01/04/2021 to 31/03/2022) (NHSBSA)	10.5%	9.2%	8.8%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
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 (01/10/2021 to 31/03/2022) (NHSBSA)	6.21	5.75	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	187.2‰	132.4‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	1.38	0.62	0.60	Tending towards variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	7.1‰	6.9‰	6.8‰	No statistical variation

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

Medicines management	
Blank prescription forms and pads 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).	Partial
There was a process for monitoring patients' health in relation to the use of medicines including high-risk medicines with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Partial
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	No
Additional evidence or comments	
<p>At our inspection in April 2022 we found blank prescription forms kept at Stonecross Surgery were not always stored in a locked cupboard when not in use. After our inspection the provider told us the filing system cabinets that blank prescription forms were stored in were now being kept locked when not in use.</p> <p>During our inspection in August 2022 we found blank prescription forms were now being stored securely in a designated locked cabinet.</p> <p>At our inspection in April 2022 we looked at eight patient group directions (PGDs) kept at Stonecross</p>	

Surgery and eight PGDs kept at West Drive Surgery. We found that none of them had had blank areas crossed through (to prevent the addition of more staff names after the authorising manager had signed the PGD). One of the PGDs had expired and none were complete records. I.e. the records kept only comprised of the practitioner authorisation sheet. Full guidance for staff using the PGDs was therefore not available to them during use.

During our inspection in August 2022 we looked at eight PGDs kept at Stonecross Surgery. We saw that they had all been updated after the deadline date of 15 July 2022 as stipulated in the Warning Notice issued after our last inspection. We found all of them had blank areas crossed through and all were in date. They had all been completed correctly except none contained the organisation name where they were to be used. However, during our inspection staff added the organisation name to all of these PGDs.

At our inspection in August 2021 we found best practice guidance for the safe management of the high-risk medicines methotrexate, azathioprine and lithium was not always applied.

At our inspection in April 2022 we found best practice guidance for the safe management of some high-risk medicines was still not always applied. For example, we looked at the records of:

- Five patients who were prescribed warfarin. We found two of these patients' records did not contain details of the dose of warfarin prescribed nor a record of the date their next blood test was due. This was not in line with best practice guidance for the management of this high-risk medicine.
- Four patients who were prescribed zopiclone (a controlled drug). We found three of these patients' records did not contain evidence to show the risks and side effects of taking this high-risk medicine had been discussed with the patient. One of these patients' records showed that they had also been prescribed another controlled drug in addition to zopiclone. However, the record did not contain evidence to show why both controlled drugs were being prescribed simultaneously. This was not in line with best practice guidance for the management of this high-risk medicine.

During our inspection in August 2022 we found best practice guidance for the safe management of some high-risk medicines continued to not always be applied. For example, we looked at the records of:

- Seven patients who were prescribed warfarin. We found one of these patients' records did not contain an up to date relevant blood test result at the time the prescription for warfarin was issued. This was not in line with best practice guidance for the management of this high-risk medicine.
- Three patients who were prescribed zopiclone. One of these patients' records showed that they had also been prescribed another controlled drug in addition to zopiclone. However, the record did not contain evidence to show why both controlled drugs were being prescribed simultaneously. The medicines had also been reissued on prescription to the patient on 27 July 2022. This was not in line with best practice guidance for the management of this high-risk medicine.

At our inspection in August 2021 NHS Business Service Authority (NHSBSA) published results showed the practice was tending towards variation negative for performance in two out of the six indicators for the prescribing of some antibiotics and hypnotics.

At the time of our inspection in April 2022 NHSBSA published results showed the practice was tending towards variation negative for performance in three out of the six indicators for the prescribing of some antibiotics and hypnotics. These results demonstrated a deterioration in performance by the

practice.

At the time of our inspection in August 2022 NHSBSA published results showed there had been insufficient improvement in the performance by the practice for the prescribing of some antibiotics and hypnotics. For example:

- In March 2021 practice results for the number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STARPU) were 0.87 (CCG average 0.74, England average 0.70). This had deteriorated by December 2021 to 1.05 (CCG average 0.79, England average 0.76). This had deteriorated further by March 2022 to 1.10 (CCG average 0.83, England average 0.79).
- In March 2021 practice results for average daily quantity per item for Nitrofurantoin 50mg tablets and capsules, Nitrofurantoin 100mg m/r capsules, Pivmecillinam 200mg tablets and Trimethoprim 200mg tablets prescribed for uncomplicated urinary tract infection (UTI) were 6.43 (CCG average 5.88, England average 5.37). This had deteriorated by December 2021 to 6.48 (CCG average 5.75, England average 5.28). Although this had improved by March 2022 to 6.21, it was still above the CCG average of 5.75 and England average of 5.29.
- In March 2021 practice results for the average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STARPU) were 1.35 (CCG average 0.69, England average 0.66). This had deteriorated by December 2021 to 1.40 (CCG average 0.63, England average 0.62). Although this had improved by March 2022 to 1.38, it was still above the CCG average of 0.62 and England average of 0.60.

At our inspection in April 2022 records showed the provider had recently started working with the local Clinical Commissioning Group (CCG) and had developed an action plan to help reduce and monitor the prescribing of antibiotics and hypnotics.

During our inspection in August 2022 staff told us the locum clinical pharmacist was tasked with addressing performance by the practice for the prescribing of some antibiotics as well as hypnotics and records confirmed this.

After our inspection in April 2022 the provider sent us evidence to show a written action plan had been developed on 10 April 2022 to help improve antimicrobial stewardship at the practice. However, the document did not indicate how staff were to be made aware of the action plan and did not contain a timeline for when actions were to be completed. For example, action six was 'Do an antibiotic audit'.

During our inspection in August 2022 staff told us an antibiotic audit had been carried out in June 2022. Records confirmed this and showed that practice staff were not complying with local prescribing guidance for some antibiotics for approximately 60% of patients included in the audit. The audit contained recommendations to improve performance. However, we looked but could not find evidence to show that these recommendations had been shared with relevant staff nor that there were plans to repeat the audit to establish if actions had resulted in improvements to performance.

At our inspection in April 2022 we found medicines that required refrigeration were stored in one designated medicines refrigerator at West Drive Surgery. We looked at the temperature monitoring records for this refrigerator. Records showed that the temperature had been recorded as being outside of the acceptable limits of between two and eight degrees centigrade on 28 occasions between 14 February 2022 and 30 March 2022. There was written guidance for staff to follow if the temperature of the designated medicines refrigerator went outside of acceptable limits. For example, the protocol for the storage of non-controlled drugs and vaccines document and an untitled document relating to vaccine supplies. We asked to see evidence to show written guidance was followed by staff on every occasion when records showed the temperature of the designated medicines refrigerators

went outside of the acceptable limits. However, we were not provided with any evidence of this.

During our inspection in August 2022 staff told us the issues we found at our last inspection regarding medicines not being stored within acceptable limits had been reported as a significant event and manufacturers of the medicines stored at that time had been contacted to establish if they were safe to continue to be administered to patients. We asked to see evidence of the significant event report and of the contact with relevant manufacturers but were not provided with any.

Safety alerts	
The practice had systems for managing safety alerts.	Yes
Information from safety alerts was shared with staff.	Yes
Staff understood how to deal with safety alerts.	Yes
The practice acted on and learned from safety alerts.	Partial
The practice kept records of action taken (or if no action was necessary) in response to receipt of all safety alerts.	Yes

Additional evidence or comments

At our inspection in August 2021 we found that although there was a system for dealing with safety alerts not all safety alerts received by the practice had been actioned.

At our inspection in April 2022 we carried out clinical searches and reviewed two safety alerts. We found that they had not always been managed well. For example, alerts relating to patients prescribed the medicine sodium valproate and patients prescribed the medicine mirabegron.

After our inspection the provider sent us evidence to show that written guidance for staff had been introduced on the management of women of childbearing age prescribed sodium valproate.

During our inspection in August 2022 we carried out clinical searches and reviewed three safety alerts. We found there had been improvements to the management of alerts relating to patients prescribed sodium valproate. However, we also found there were ongoing issues in the management of alerts relating to patients prescribed mirabegron and issues in the management of alerts relating to patients prescribed escitalopram / citalopram. For example, we looked at the records of:

- Five patients who were prescribed mirabegron. There was no evidence to show three of these patients had been informed of the risks of taking this medicine. Records also showed the dosage of mirabegron prescribed for two other of these patients was too high as their blood test results indicated a lower dose of mirabegron was safer and in line with best practice guidance.
- Four patients who were prescribed escitalopram / citalopram. There was no evidence to show any of these patients had been informed of the risks of taking these medicines. Records also showed one of these patients was over the age of 65 years and was being prescribed 30mg of escitalopram when the maximum safe dosage of this medicine for people over the age of 65 years was 10mg.

Effective

Rating: Not Rated

The practice was not rated as a result of this inspection. Our findings were as follows:

- Patients' needs were still not always assessed, and care as well as treatment were not always delivered in line with current legislation, standards and evidence-based guidance.
- There was still not an effective programme of quality improvement activity that routinely reviewed the effectiveness and appropriateness of the care provided.
- Staff had the skills, knowledge and experience to carry out their roles. However, not all staff were up to date with essential training and not all staff had access to regular appraisals.
- Staff were still not always consistent and proactive in helping patients to live healthier lives.

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

Effective needs assessment, care and treatment

Patients' needs were still not always assessed, and care as well as treatment were not always delivered in line with current legislation, standards and evidence-based guidance.

Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	No
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	No
Patients' treatment was regularly reviewed and updated.	No
Additional evidence or comments	
At our inspection in April 2022 we found patients with long-term conditions, such as asthma, chronic obstructive pulmonary disease (COPD), diabetes, atrial fibrillation (AF) and patients experiencing poor mental health (including dementia) were not always receiving relevant reviews in line with best practice guidance.	
During our inspection in August 2022 we found patients with long-term conditions, such as chronic obstructive pulmonary disease (COPD), diabetes, atrial fibrillation (AF) and patients experiencing poor mental health (including dementia) were still not always receiving relevant reviews in line with best practice guidance.	

Monitoring care and treatment

The practice continued to not have an effective programme of quality improvement activity that routinely reviewed the effectiveness and appropriateness of the care provided.

The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Partial
Additional evidence or comments	
<p>At our inspection in April 2022 we found the practice's programme of quality improvement activity had failed to identify improvements to the quality and safety of the following patient groups was required:</p> <ul style="list-style-type: none">• Children that were on the at risk register.• Patients who were prescribed any of these high-risk medicines: warfarin; and some controlled drugs.• Patients who were diagnosed with: asthma, chronic obstructive pulmonary disease (COPD); diabetes; atrial fibrillation (AF); mental health conditions; and dementia.• Patients who were prescribed the following medicines for long-term conditions: women who were prescribed sodium valproate; patients who were prescribed mirabegron. <p>During our inspection in August 2022 we found the practice's programme of quality improvement activity had identified improvements to the quality and safety of the following groups were required and action had been taken by the provider:</p> <ul style="list-style-type: none">• Patients who were diagnosed with asthma.• Patients who were prescribed sodium valproate. <p>We also found the practice's programme of quality improvement activity had identified improvements to the quality and safety of the following patient groups were required:</p> <ul style="list-style-type: none">• Children that were on the at risk register.• Patients who were prescribed any of these high-risk medicines: warfarin; and some controlled drugs.• Patients who were diagnosed with: chronic obstructive pulmonary disease (COPD); diabetes; atrial fibrillation (AF); mental health conditions; and dementia.• Patients who were prescribed mirabegron. <p>However, action taken by the provider to improve the quality and safety of these groups of patients was insufficient.</p> <p>We also found the practice's programme of quality improvement activity had failed to identify improvements to the quality and safety of patients who were prescribed escitalopram / citalopram.</p>	

Effective care for the practice population

Management of people with long-term conditions

Findings

At our inspection in August 2021 we found patients with long-term conditions were not always offered a structured annual review to check their health as well as medicines needs were being met and care as well as treatment were not always delivered in line with current legislation, standards and evidence-based guidance. For example, patients diagnosed with: atrial fibrillation (AF); hypertension; and patients prescribed gabapentinoids.

At our inspection in April 2022 we found all patients with long-term conditions were still not always offered a structured annual review to check their health as well as medicines needs were being met and care as well as treatment were not always delivered in line with current legislation, standards and evidence-based guidance.

We looked at the records of:

- Five patients who were diagnosed with asthma. For one of these patients we looked but could not find evidence of a record of their smoking status.
- Five patients who were diagnosed with chronic obstructive pulmonary disease (COPD). We looked but could not find any evidence to show that any of these patients' reviews followed best practice guidance (Global Initiative for Chronic Obstructive Lung Disease – GOLD guidance).
- Five patients who were diagnosed with diabetes. One of these patients' records showed that a medication review had been carried out in June 2021 when their HbA1c blood test result was recorded as being very high. We looked but could not find evidence to show that any further follow-up had taken place since June 2021, nor that eye screening had been carried out. Another of these patients' records showed that their prescribed insulin had been increased in June 2021. We looked but could not find evidence to show that any further follow-up had taken place since June 2021, nor that a foot check had been carried out. This patient's records also showed that their blood pressure had been recorded as above target, but we looked but could not find evidence to show that this had been treated or followed up.
- Five patients who were diagnosed with atrial fibrillation (AF). One of these patients' records did not contain a CHADSVASC score (a scoring method used to predict a patient's thromboembolic risk) and there was no evidence to show they were being prescribed relevant anticoagulation medicine. Another of these patients' records showed that their blood pressure had been recorded as being high but there was no evidence to show that they were being prescribed relevant antihypertensive medicine.
- Five patients who were diagnosed with mental health conditions. Four of these patients' records showed that the patients had not had relevant blood tests carried out in line with best practice guidance. For example, one of these patients' records showed that they had not had relevant blood tests carried out since 2019. Another of these patients' records showed that they had also been diagnosed with diabetes, but they had not had relevant blood tests carried out since 2020. One of these patients' records did not contain a record of their smoking status.
- Five patients who were diagnosed with dementia. Four of these patients' records did not contain evidence that the patients' resuscitation status had been discussed with the patient or their relatives / advocates.
- We looked at the records of three patients who were receiving palliative care and found that end of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. However, one of these records did not contain

evidence that the patients' resuscitation status had been discussed with the patient or their relatives / advocates.

During our inspection in August 2022 we found all patients with long-term conditions were still not always offered a structured annual review to check their health as well as medicines needs were being met and care as well as treatment were not always delivered in line with current legislation, standards and evidence-based guidance.

We looked at the records of:

- Nine patients who were diagnosed with chronic obstructive pulmonary disease (COPD). There was no evidence to show that any of these patients' reviews followed best practice guidance (Global Initiative for Chronic Obstructive Lung Disease – GOLD guidance). Records of one of these patients also showed they had been diagnosed with diabetes. However, there was no evidence to show that any relevant blood tests had been carried out since November 2021. Records of another of these patients also showed they were prescribed an ACE inhibitor and carbamazepine. However, there was no evidence to show that any relevant blood tests had been carried out since August 2021.
- Six patients who were diagnosed with diabetes and found evidence that care and treatment was not being delivered in a safe way for all six of these patients. For example, records of one of these patients showed they had been diagnosed with diabetes in 2015. There was no evidence to show they had received relevant blood tests or a foot check since then. Records of another of these patients showed their prescribed insulin dosage had been increased but they were not due to be followed up for 12 months. This was not in line with best practice guidance. There was no evidence to show a foot check had been carried out for this patient nor their raised blood pressure had been followed up.
- Five patients who were diagnosed with atrial fibrillation (AF) and found they were also prescribed bisoprolol as well as relevant medicines to treat their AF. However, there was no evidence to show they had had their blood pressure checked since August 2020. This was not in line with best practice guidance.
- Five patients who were diagnosed with mental health conditions. There was no evidence to show any of these patients had blood tests carried out in line with best practice guidance. Records of two of these patients showed their blood pressure had been recorded as being too high. However, there was no evidence to show that either of these patients had been followed up.
- Six patients who were diagnosed with dementia. For one of these patients there was no evidence to show that their resuscitation status had been discussed with them or their relatives / advocates.
- We looked at the records of six patients who were receiving palliative care and found that end of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. However, five of these records had no evidence that the patients' resuscitation status had been discussed with the patient or their relatives / advocates.

Records showed there were 79 patients on the practice register who were diagnosed with mental health conditions. However, there was no evidence to show that 55 of these patients had received a mental health review within the last 12 months in line with best practice guidance.

Records showed that there were 30 patients on the practice register who were diagnosed with dementia. However, there was no evidence to show that 22 of these patients had received a dementia review within the last 12 months in line with best practice guidance.

At our inspection in April 2022 records showed the provider had recently started working with the local Clinical Commissioning Group (CCG) and an external organisation to help improve performance in

relation to the management of the care and treatment of patients with long-term conditions. Action plans had been developed but these did not contain time frames by which action was to be taken and were ongoing.

During our inspection in August 2022 staff told us that the action plans developed to help improve performance in relation to the management of the care and treatment of patients with long-term conditions had been updated and time frames added. However, we asked to see the updated action plan and were given a printout of a list of patients diagnosed with hypertension. This was not the updated action plan and we were not provided with any further evidence that it had been updated.

At our inspection in August 2021 we completed a series of searches on the practice's clinical record system. These searches were completed to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance. Our searches showed that the practice had failed to identify some patients with commonly undiagnosed conditions. For example, diabetes. This meant that these patients were not always receiving the care and treatment they needed. For example, retinal screening and foot checks.

At our inspection in April 2022 we completed a series of searches on the practice's clinical record system. These searches were completed to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance. Our searches showed that the practice had failed to identify some patients with commonly undiagnosed conditions. For example, chronic kidney disease (CKD) and diabetes. This meant that these patients were not always receiving the care and treatment they needed. For example, blood pressure checks, retinal screening and foot checks.

After our inspection the provider wrote to us and told us that patients identified by the searches we carried out that potentially were diabetic (22 in total) were being reviewed by a GP. They told us that repeat blood tests and appointments were being arranged as appropriate for these patients.

During our inspection in August 2022 we completed a series of searches on the practice's clinical record system. These searches were completed to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance. Our searches showed that the practice had failed to identify some patients with commonly undiagnosed conditions. For example, chronic kidney disease (CKD) (seven in total) and diabetes (one patient). This meant that these patients were not always receiving the care and treatment they needed. For example, blood pressure checks, retinal screening and foot checks. This placed them at risk of harm.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	80	89	89.9%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	86	102	84.3%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	87	102	85.3%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	87	102	85.3%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	75	94	79.8%	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>

Additional evidence or comments

At the time of our inspection in August 2021 NHS England results (published in March 2020) showed that uptake rates for childhood immunisations met the target rate of 90% or above in all five indicators.

At the time of our inspection in April 2022 NHS England results (published in March 2021) showed that uptake rates for childhood immunisations had deteriorated and were now lower than the target of 90% or above in all five indicators.

Staff told us that these results were partly due to some children's parents' reluctance to have their children immunised. They also told us that the practice nurse had reduced the number of sessions they delivered which had resulted in fewer appointment during which to administrate childhood immunisations being available.

The provider was aware of the practice's performance in relation to childhood immunisations and had taken some action in order to make improvements. For example:

- Invitations were being sent by text message as well as letter and telephone calls were being made to the parents of patients eligible for childhood immunisations to encourage attendance at the practice.
- Two practice nurses had been recruited and were due to commence employment at the practice in April 2022. This would increase the number of appointments available during which to deliver childhood immunisations.

During our inspection in August 2022 staff told us they were continuing to take action to make improvements in uptake of childhood immunisations. For example:

- One administrator had been designated to make calls to the parents of children who were either due or overdue childhood immunisations.
- One locum practice nurse had been employed one day per week to increase the number of appointments where childhood immunisations could be administered.
- GPs were able to administer childhood immunisation if necessary.

We asked what impact on performance these actions had made relating to childhood immunisations, but staff told us they were not aware of the impact these measures had made.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	69.4%	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) (UKHSA)	69.5%	63.4%	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) (UKHSA)	64.2%	68.0%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	42.9%	56.4%	55.4%	No statistical variation

Additional evidence or comments

At the time of our inspection in August 2021 Public Health England (PHE) published results showed that the practice's uptake for cervical screening as at March 2020 was 70.2%. This was below the 80% coverage target for the national screening programme.

At the time of our inspection in April 2022 PHE published results showed that the practice's uptake for cervical screening as at March 2021 had deteriorated to 69.1%. This was still below the 80% coverage target for the national screening programme. However, unverified data showed that uptake rates had improved since then but remained below the 80% coverage target:

- 71% of eligible patients aged 50 to 64 years registered at the practice had received cervical screening.
- 80% of eligible patients aged 25 to 49 years registered at the practice had received cervical screening.

The provider was aware of the practice's performance in relation to cervical screening and had implemented an action plan in order to make improvements. For example:

- Invitations were being sent by text message as well as letter and telephone calls were being made to patients eligible for cervical screening to encourage attendance at the practice.

During our inspection in August 2022 staff told us they were continuing to take action to make improvements in uptake of cervical screening. For example:

- Staff were making calls to eligible patients who were either due or overdue for cervical screening.
- One locum practice nurse had been employed one day per week to increase the number of appointments where cervical screening could be carried out.
- GPs were able to carry out cervical screening if required.

We asked what impact on performance these actions had made relating to cervical screening, but staff told us they were not aware of the impact these measures had made.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. However, not all staff were up to date with essential training and not all staff had access to regular appraisals.

There was an induction programme for new staff.	Yes
The learning and development needs of all staff were assessed.	Yes
All staff were up to date with essential training.	No
All staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation.	No
Clinical staff 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.	Yes
There was a clear approach for supporting and managing staff when their performance was poor or variable.	Yes

Additional evidence or comments

At our inspection in April 2022 we found not all relevant staff were up to date with: safeguarding training; fire safety training; fire marshal training; infection prevention and control training; basic life support training; and recognition and management of patients with severe infections such as sepsis training.

During our inspection in August 2022 we found staff were still not up to date with fire safety training and infection prevention and control training.

At our inspection in August 2021 we found that not all staff had received regular appraisals. However, a schedule of appraisals had been planned for those staff who required one.

At our inspection in April 2022 we asked to see the appraisal records for five members of staff. We were not provided with these records for two members of staff so we could not be sure if they had received an appraisal or not.

During our inspection in August 2022 records showed one of the members of staff for whom we were not provided evidence of their appraisal had received an appraisal in November 2021. However, we were not provided with any records to show an appraisal had taken place for the other member of staff for whom we were not provided evidence of their appraisal at our last inspection.

Helping patients to live healthier lives

Staff were still not always consistent and proactive in helping patients to live healthier lives.

Patients had access to appropriate health assessments and checks.	No
Additional evidence or comments	
At our inspection in April 2022 we found patients with long-term conditions were not always offered a structured annual review to check their health and medicines needs were being met.	
During our inspection in August 2022 we found patients with long-term conditions were still not always offered a structured annual review to check their health and medicines needs were being met.	

Caring

Rating: Not Rated

The practice was not rated as a result of this inspection. Our findings were as follows:

- Patients were still not always given appropriate and timely information to cope emotionally with their care, treatment or condition.
- National GP patient survey results published in July 2022 demonstrated a deterioration in all patient satisfaction scores relating to care and treatment delivered by this practice.
- Staff continued to not always communicate with patients in a way that helped them to understand their care, treatment and condition, and any advice given.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Partial
Additional evidence or comments	
<p>At our inspection in April 2022 records that we looked at demonstrated that patients were not always given appropriate and timely information to cope emotionally with their care, treatment or condition. For example:</p> <ul style="list-style-type: none">• Patients who were prescribed high-risk medicines such as controlled drugs.• Patients who were diagnosed with diabetes or dementia and patients who were receiving palliative care.• Patients who were prescribed the medicines sodium valproate or mirabegron for long-term conditions. <p>During our inspection in August 2022 records that we looked at demonstrated that patients were still not always given appropriate and timely information to cope emotionally with their care, treatment or condition. For example:</p> <ul style="list-style-type: none">• Patients who were prescribed high-risk medicines such as controlled drugs.• Patients who were diagnosed with diabetes or dementia and patients who were receiving palliative care.• Patients who were prescribed the medicines mirabegron or escitalopram / citalopram for long-term conditions.	

National GP Patient Survey Results published in July 2022

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 (01/01/2022 to 30/04/2022)	66.7%	82.1%	84.7%	Variation (negative)
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 (01/01/2022 to 30/04/2022)	59.8%	80.8%	83.5%	Variation (negative)
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 (01/01/2022 to 30/04/2022)	79.3%	92.0%	93.1%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	46.5%	66.8%	72.4%	Variation (negative)
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 (01/01/2022 to 30/04/2022)	83.1%	89.0%	89.9%	No statistical variation

Additional evidence or comments

National GP patient survey results published in July 2022 showed that patient satisfaction scores regarding care and treatment had deteriorated. Staff told us that an action plan was in the process of being developed to address these results. However, we saw that the action plan did not yet include actions to improve patient satisfaction scores regarding care and treatment.

Involvement in decisions about care and treatment

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

Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Partial
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Additional evidence or comments

At our inspection in April 2022 records that we looked at demonstrated that staff did not always communicate with patients in a way that helped them to understand their care, treatment and condition, and any advice given. For example:

- Patients who were prescribed high-risk medicines such as controlled drugs.
- Patients who were diagnosed with diabetes or dementia and patients who were receiving palliative care.
- Patients who were prescribed the medicines sodium valproate or mirabegron for long-term conditions.

During our inspection in August 2022 records that we looked at demonstrated that staff were still not always communicating with patients in a way that helped them to understand their care, treatment and condition, and any advice given. For example:

- Patients who were prescribed high-risk medicines such as controlled drugs.
- Patients who were diagnosed with diabetes or dementia and patients who were receiving palliative care.
- Patients who were prescribed the medicines mirabegron or escitalopram / citalopram for long-term conditions.

Responsive

Rating: Not Rated

The practice was not rated as a result of this inspection. Our findings were as follows:

- The practice organised and delivered services but these continued to not always meet patients' needs.
- People were still not always able to access care and treatment in a timely manner as insufficient nursing staff were employed in order to meet patients' needs.
- National GP patient survey results published in July 2022 demonstrated a deterioration in all patient satisfaction scores relating to access at this practice.

Responding to and meeting people's needs

The practice organised and delivered services but these continued to not always meet patients' needs.

Additional evidence or comments	
The practice understood the needs of its local population and had developed services in response to those needs.	Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Partial
At our inspection in April 2022 records that we looked at demonstrated that the practice did not fully understand the needs of its local population and had not developed or improved services in response to those needs of: <ul style="list-style-type: none">• Patients who were prescribed any of these high-risk medicines: warfarin; controlled drugs.• Patients who were diagnosed with: asthma, chronic obstructive pulmonary disease (COPD); diabetes; atrial fibrillation (AF); mental health conditions; and dementia.• Patients who were prescribed the following medicines for long-term conditions: sodium valproate; mirabegron.	
During our inspection in August 2022 records that we looked at demonstrated that the practice continued not to fully understand the needs of its local population and had not sufficiently developed or improved services in response to those needs of: <ul style="list-style-type: none">• Patients who were prescribed any of these high-risk medicines: warfarin; controlled drugs.• Patients who were diagnosed with: chronic obstructive pulmonary disease (COPD); diabetes; atrial fibrillation (AF); mental health conditions; and dementia.• Patients who were prescribed the following medicines for long-term conditions: mirabegron; escitalopram / citalopram.	

Access to the service

People were still not always 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.

Practice Opening Times	
Stonecross Surgery	
Day	Time
Monday	8am to 12pm and 2pm to 6.30pm
Tuesday	8am to 12pm and 2pm to 6.30pm
Wednesday	8am to 12pm and 2pm to 6.30pm
Thursday	8am to 12pm and 2pm to 6.30pm
Friday	8am to 12pm and 2pm to 6.30pm
West Drive Surgery	
Day	Time
Monday	8am to 12pm and 2pm to 6.30pm
Tuesday	8am to 12pm
Wednesday	8am to 12pm and 2pm to 6.30pm
Thursday	8am to 12pm and 2pm to 6.30pm
Friday	8am to 12pm and 2pm to 6.30pm

Patients were able to make appointments in a way which met their needs.	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.	Partial
There were enough staff to provide appointments and prevent staff from working excessive hours.	No

Additional evidence or comments	
At our inspection in April 2022 we found the practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs. However, patients were required to telephone the practice at 8am or 2pm in order to book an appointment on the day. We looked at the practice's appointments system and saw the next available pre-bookable telephone consultation with a GP was 1 April 2022. The practice was not operating a pre-bookable face to face GP appointments	

system outside of on the day. Staff told us patients were not able to book appointments online.

During our inspection in August 2022 we found that improvements had been made to the way patients were able to access care and treatment. Patients were now able to book appointments in person as well as by telephoning the practice at any time during their normal opening hours. Patients were able to book pre-bookable appointments, including face to face appointments with a GP, as well as some on the day appointments with GPs and nurses for urgent matters. On the day of our inspection (5 August 2022) we looked at the practice's appointment system and saw:

- The next available telephone appointment with a GP was 5 August 2022.
- The next available face to face appointment with a GP was 5 August 2022.

However, staff told us that patients were still not able to book appointments with any practice clinician online as this had not yet be reinstated.

At our inspection in April 2022 we found insufficient nursing staff were employed in order to meet patients' needs. The practice employed one nurse who worked at Stonecross Surgery one day each week and West Drive Surgery one day each week. Another nurse was employed at the practice. We asked for details of this nurse's whole time equivalent (WTE) and pattern of weekly work but were not provided with this information.

Staff told us that additional nursing staff were being recruited as the practice was unable to provide sufficient appointments during which to administer childhood immunisations or carry out cervical screening.

During our inspection in August 2022 staff told us the practice nurse was no longer working for the practice. They also told us that one of the HCAs was no longer working for the practice and the other HCA would be leaving in the near future. This meant once the second HCA had left the practice there would be no HCAs employed to help meet patients' needs.

Staff told us that a locum practice nurse was now being employed one day per week and a practice nurse had been recruited and was employed three days per week. Although this demonstrated an increase in the number of practice nurses currently being employed we were not provided with any evidence of the impact of this increase (nor of the loss of the HCA) on patient care.

National GP Patient Survey Results published in July 2022

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 telephone (01/01/2022 to 30/04/2022)	33.3%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	32.9%	48.6%	56.2%	Tending towards variation (negative)

The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	30.1%	48.2%	55.2%	Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	52.3%	68.2%	71.9%	Tending towards variation (negative)

Additional evidence or comments

At our inspection in April 2022 staff told us they were not aware of the latest published results from the national GP patient survey and there were no plans to improve patient satisfaction scores. However, additional funding had been secured by the provider and additional staff were being employed that would in turn increase the availability of appointments and clinics.

At the time of our inspection in August 2022 national GP patient survey results published in July 2022 showed that patient satisfaction scores regarding access had deteriorated. Staff told us that an action plan was in the process of being developed and implemented to address these results. The action plan included actions to improve patient satisfaction scores regarding access but these had not yet been implemented. For example, a new telephone system was due to be installed in September 2022.

Well-led

Rating: Not Rated

The practice was not rated as a result of this inspection. Our findings were as follows:

- Leaders had not taken sufficient action on all required improvements to quality, safety and performance which placed patients at continued risk of harm.
- The practice had a vision to deliver high quality care and promote good outcomes for patients. However, they were continuing to fail to meet this vision.
- Improvements to processes for managing risks, issues and performance were still insufficient.
- The provider had systems to continue to deliver services, respond to risk and meet patients' needs during the pandemic. However, these were still not always effective.
- The practice did not always act on appropriate and accurate information. Quality and operational information were still not always being used effectively to help monitor and improve performance.
- The practice did not always involve the public, staff and external partners to help ensure they delivered high-quality and sustainable care. Improvements were still required.

Leadership, capacity and capability

There was compassionate and inclusive leadership at all levels. However, leaders had not taken sufficient action on all required improvements to quality, safety and performance.

Leaders demonstrated that they understood the challenges to quality and sustainability.	No
Leaders had identified the actions necessary to address these challenges.	No
Additional evidence or comments	
At our inspection in April 2022 we found clinical leadership at Stonecross and West Drive Surgery was provided by one of the GP partners. Clinical supervision was provided by two of the GP partners, but staff were able to contact any of the four GP partners for relevant support and guidance at any time if required.	
We found that there was a lack of awareness by leaders that improvements to quality, safety and performance were required in relation to the following:	
<ul style="list-style-type: none">• Safeguarding.• Fire safety.• Infection prevention and control.• Risk management.• Medicines management.• Safety alerts management.• Reviews of patients with some long-term conditions.• Staff training.	
During our inspection in August 2022 we found there had been no change to the arrangements for	

clinical leadership or clinical supervision.

Although there had been an improvement in the awareness by leaders that improvements to quality, safety and performance were required they had not taken sufficient action to adequately address issues regarding:

- Safeguarding.
- Fire safety.
- Infection prevention and control.
- Risk management.
- Medicines management.
- Safety alerts management.
- Reviews of patients with some long-term conditions.
- Staff training.

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients. However, they were continuing to fail to meet this vision.

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.	No
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.	Partial
Additional evidence or comments	
At our inspection in April 2022 we found the provider had a mission statement which reflected the visions of the practice to ensure accessible, high-quality, comprehensive services were available for all communities with their catchment area. However, based on our inspection findings they were failing to meet this vision.	
During our inspection in August 2022, based upon our findings, the provider was continuing to fail to meet this vision.	

Governance arrangements

Processes and systems to support good governance and management were still not always effective.

There was a clear staffing structure and staff were aware of their own roles and responsibilities.	Yes

The provider had systems that helped to keep governance documents up to date.	Partial
Governance documents that we looked at were up to date.	Yes
Additional evidence or comments	
<p>At our inspection in April 2022 we asked to see the written job descriptions of five staff that were used to help staff awareness of their own roles and responsibilities. We were not provided with these records for one member of clinical staff so we could not be sure that they had a written job description. We were sent records that described a practice manager and secretary role as the written job description for a receptionist. This member of staff did not, therefore, have the correct written job description for their role in the practice.</p> <p>During our inspection in August 2022 records showed appropriate and correct written job descriptions were now available for the member of staff for whom we were not provided a job description and the member of staff who did not have the correct written job description for their role in the practice.</p> <p>At our inspection we looked at 21 governance documents and found that one was not dated so we could not be sure when it came into force. We also found that 16 of these documents did not contain a planned review date to help ensure they were kept up to date.</p> <p>The vulnerable adults policy was two pages long and contained minimal information to guide staff they had concerns about a patient's welfare. The document did not contain contact details of local safeguarding authorities. The document did name the GP partner who was the safeguarding lead but did not detail other staff's responsibilities in relation to safeguarding vulnerable adults nor staff training requirements.</p> <p>The policy for health and safety at work had been reviewed in March 2022. However, it detailed a member of staff as a fire warden who no longer worked at the practice and was, therefore, not up to date.</p> <p>During our inspection in August 2022 we looked at 12 governance documents and found they had all been reviewed in July 2022. However, none of these documents contained a planned review date so we could not be sure the provider had plans to keep them up to date.</p>	

Managing risks, issues and performance

Improvements to processes for managing risks, issues and performance were insufficient.

Additional evidence or comments	
There were effective arrangements for identifying, recording, managing and mitigating risks.	No
Records showed that all clinical audits had been repeated or were due to be repeated to complete the cycle of clinical audit.	Partial
Additional evidence or comments	
<p>At our inspection in April 2022 the provider was unable to demonstrate their processes and systems were effective in the management of risks from:</p> <ul style="list-style-type: none"> The practice's computer system not alerting staff of all family and other household members of children that were on the risk register. 	

- Not maintaining staff vaccination in line with current Public Health England (PHE) guidance.
- Management of fire safety.
- Management of all identifiable infection prevention and control risks.
- The lack of availability of all emergency equipment and emergency medicines that were required to be kept.
- Management of all health and safety risks.
- Management of all risks from legionella.
- Management of blank prescription forms.
- Management of appropriate authorisations to allow staff to administer medicines.
- Management of the prescribing of some high-risk medicines.
- Management of medicines that required refrigeration.
- Management of safety alerts.
- All staff not being up to date with relevant training.

During our inspection in August 2022 we found improvements had been made so processes and systems were now effective in the management of risks from:

- Not maintaining staff vaccination in line with current Public Health England (PHE) guidance.
- The lack of availability of all emergency equipment and emergency medicines that were required to be kept.
- Management of blank prescription forms.
- Management of appropriate authorisations to allow staff to administer medicines.

However, insufficient improvements had been made to systems and processes that managed risks from:

- The practice's computer system not alerting staff of all family and other household members of children that were on the risk register.
- Management of all identifiable infection prevention and control risks.
- Management of all health and safety risks.
- Management of all risks from legionella.
- Management of the prescribing of some high-risk medicines.
- Management of safety alerts.
- All staff not being up to date with relevant training.

At our inspection in April 2022 we found some processes to manage current and future performance were not sufficiently effective. This was partly due to limitations imposed on services by the pandemic. For example, breast and bowel cancer screening was suspended by Public Health England for a time during the pandemic. The practice also had to adapt the way they delivered services during the pandemic to reduce the risks from COVID-19 to patients and staff. However, improvements to care and treatment were required for some types of patient reviews as well as subsequent follow-up activities. For example, asthma reviews, chronic obstructive pulmonary disease (COPD) reviews, diabetes reviews, atrial fibrillation reviews, mental health reviews and dementia reviews. Improvements were also required to performance related to child immunisations and cervical screening.

During our inspection in August 2022 we found some processes to manage current and future performance were still not sufficiently effective. Further improvements to care and treatment were required for some types of patient reviews as well as subsequent follow-up activities. For example, chronic obstructive pulmonary disease (COPD) reviews, diabetes reviews, atrial fibrillation reviews, mental health reviews and dementia reviews. Further improvements were also required to performance related to child immunisations and cervical screening.

At our inspection in April 2022 we asked to see clinical audits that had been completed at Stonecross and West Drive Surgery during the last 12 months.

One clinical audit had been carried out on 31 March 2021 (an audit of new cancer diagnosis in patients not referred by the two week wait pathway). Results had been analysed and showed that performance was 22.7% which was below the set standard of 30%. The audit contained an action plan to improve performance and there were plans to repeat this audit within 12 months. However, we were not provided with evidence to show that this had been repeated to complete the cycle of clinical audit.

Two other clinical audits had been carried out within the last 12 months (an audit of the prescribing of vitamin D and an audit of the safe administration of DOAC medicine). Both audits were second cycles (completing the cycle of clinical audit) and both demonstrated improvement in performance of the practice. For example, 91.6% of patients were prescribed vitamin D on acute prescriptions compared to 89.3% that was established by the first cycle audit. However, this was still below the set standard of 100%. Results of the DOAC medicine administration audit demonstrated a significant improvement from 4% in August 2021 to 96.6% in March 2022. Both audits contained action plans to continue to make improvements in performance. However, only one audit contained plans to repeat the audit and monitor the effectiveness of the action plans.

During our inspection in August 2022 records showed the audit of the safe administration of DOAC medicine had been repeated in June 2022. Results demonstrated an improvement in performance relating to relevant blood tests being carried out and the recording of patients' height. Minor improvement was still required relating to the recording of patients' weights. The audit contained an action plan to continue to make improvements and there were plans to repeat the audit further in September 2022.

However, the audit of new cancer diagnosis in patients not referred by the two week wait pathway carried out in March 2021 and that was due to be repeated within 12 months, had not been repeated to complete the cycle of clinical audit. This placed patients at risk of harm.

The provider had systems to continue to deliver services, respond to risk and meet patients' needs during the pandemic. However, these were still not always effective.

The practice actively monitored the quality of access and made improvements in response to findings.	No
There were recovery plans to help manage backlogs of activity and delays to treatment.	No
Additional evidence or comments	
At our inspection in April 2022, whilst the provider was in the process of recruiting additional nursing staff, insufficient staff were employed in order to meet patients' needs.	
Performance relating to child immunisations and cervical screening had deteriorated and were still below minimum uptake targets. Although the provider was taking action to increase uptake, improvements were still required to performance relating to child immunisations and cervical screening for eligible patients aged 50 to 64 years.	

During our inspection in August 2022 staff told us the practice nurse was no longer working for the practice. They also told us that one of the HCAs was no longer working for the practice and the other HCA would be leaving the practice in the near future. This meant once the second HCA had left the practice there would be no HCAs employed to help meet patients' needs.

Staff told us that a locum practice nurse was now being employed one day per week and a practice nurse had been recruited and was employed three days per week. Although this demonstrated an increase in the number of practice nurses currently being employed by the practice we were not provided with any evidence of the impact of this increase (nor of the loss of the HCA) on patient care.

Performance relating to child immunisations and cervical screening had deteriorated and were still below minimum uptake targets. Although the provider was taking action to increase uptake, improvements were still required to performance relating to child immunisations and cervical screening for eligible patients.

Appropriate and accurate information

The practice acted on appropriate and accurate information. However, quality and operational information was still not always being used effectively to help monitor and improve performance.

Quality and operation information was used to help monitor and improve performance.	No
There were arrangements in line with data security standards for the integrity and confidentiality of patient identifiable data, records and data management systems.	Yes
Additional evidence or comments	
At our inspection in April 2022, although some quality and operational information was used to help monitor performance, it was not effective in identifying or making required improvements to all areas of performance.	
During our inspection in August 2022 we found the use of quality and operational information was still not always being used effectively to help monitor and improve all areas of performance.	
At our inspection in April 2022 we found a cupboard containing patient records was accessible to patients and visitors at Stonecross Surgery. For example, letters referring patients to other services. We told staff about this, but they were unable to lock the cupboard as they were unable to locate the relevant key.	
During our inspection in August 2022 we found this cupboard was now being kept locked when not in use.	

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to help ensure they delivered high-quality and sustainable care. However, improvements were still required.

Patient views were acted on to improve services and culture.	No
The practice gathered feedback from patients through analysis of the results of the national GP patient survey.	No
Additional evidence or comments	
<p>At our inspection in April 2022 we found the practice had not monitored feedback received from the national GP patient survey. Staff told us they were not aware of the latest published results from the national GP patient survey and there were no plans to improve patient satisfaction scores.</p> <p>At the time of our inspection in August 2022 national GP patient survey results published in July 2022 showed that patient satisfaction scores had deteriorated. Staff told us that an action plan was in the process of being developed and implemented to address these results. The action plan included actions to improve patient satisfaction scores regarding access but these had not yet been implemented. For example, a new telephone system was due to be installed in September 2022. The action plan did not include actions to improve patient satisfaction scores regarding care and treatment.</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.
- **UKHSA:** UK Health and Security Agency.
- **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.