

# Care Quality Commission

## Inspection Evidence Table

**Dr Shabir Bhatti (1-2715509380)**

**Inspection date: 23 January 2019**

**Date of data download: 15 January 2019**

## Overall rating: Inadequate

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

### Safe

**Rating: Requires improvement**

#### Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding.	Yes <sup>1</sup>
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes <sup>2</sup>
Policies were accessible to all staff.	Yes
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Partial <sup>3</sup>
There was active and appropriate engagement in local safeguarding processes.	Yes
There were systems to identify vulnerable patients on record.	Yes
There was a risk register of specific patients.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes <sup>4</sup>
Explanation of any answers and additional evidence:	
1. Many of the practice's policies and procedures had been updated since our last comprehensive	

<b>Safeguarding</b>	<b>Y/N/Partial</b>
inspection to provide more detailed guidance to staff.	
2. The provider informed us that they had sought external advice in the review and development of their policies since our last comprehensive inspection, but had sought to develop them in line with their operational processes, or improved processes.	
3. We saw evidence during the inspection that the clinical staff were trained to level three in safeguarding children and vulnerable adults. Most of the non-clinical staff (administrators and reception team) had also received training to level 1 and 2 safeguarding children. Non-clinical staff had completed level 1 training in safeguarding adults.	
4. We saw evidence that the practice had processes in place to escalate concerns about patients to relevant third parties.	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Staff had any necessary medical indemnity insurance.	Yes
Explanation of any answers and additional evidence: Staff records were maintained and held evidence to show appropriate recruitment checks were carried out, and updated records were maintained.	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: July 2018	Yes
There was a record of equipment calibration. Date of last calibration: July 2018	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: September 2018	Yes
There was a log of fire drills. Date of last drill: June 2018	Yes
There was a record of fire alarm checks. Date of last check: January 2019	Yes

There was a record of fire training for staff. Date of last training: Various	Yes <sup>5</sup>
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion:	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: 5. Fire safety training had been completed by ten members of the staff team within the last 12 months. Six members of staff had not completed fire safety training, and three members of staff had completed them in October or December 2016. The two members of staff who were the designated fire wardens had completed fire warden training in January 2019.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Yes
Explanation of any answers and additional evidence:	

## Infection prevention and control

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

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control. Date of last infection prevention and control audit:	No <sup>6</sup> _7
The practice had acted on any issues identified in infection prevention and control audits.	N/A <sup>8</sup>
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: 6. Infection prevention and control (IPC) training was available on the practice's list of training topics provided to clinical and non-clinical staff. Some clinical staff had completed the module aimed at clinical staff, but they had completed the module in 2016. Only one clinician had completed the module in 2019. Four members of the non-clinical staff team had completed the non-clinical IPC module, and nine members of staff had not completed the module. 7. NHS property services carried out weekly infection prevention and control (IPC) checks, and took responsibility for addressing any issues found. The practice was updated on the progress of remedial actions. A Legionella risk assessment had been completed 01/05/18.	

8. The practice did not undertake its own IPC checks.

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes <sup>9</sup>
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes <sup>10</sup>
There was a process in the practice for urgent clinical review of such patients.	Yes
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Yes
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>9. Following our last comprehensive inspection, the provider sent us training certificates confirming that the doctors had completed training sessions in sepsis in primary care and paediatrics on 7 August 2018.</p> <p>10. Following their training, one of the GP partners had provided most of the administrative staff with an overview session on sepsis. The provider had also added a training module on sepsis to their mandatory training programme delivered through an online provider. We saw evidence that the nonclinical staff team, with one exception, had completed the training module in sepsis awareness during January 2019.</p>	

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented.	Yes
There was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes <sup>11</sup>
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes <sup>12</sup>
Explanation of any answers and additional evidence: 11. We looked at the system for the management of test results, and found that they had been dealt with appropriately and in a timely manner. 12. we looked at a sample patient records where referrals were made, and we saw these were made appropriately with suitable supporting information provided along with the referrals.	

## Appropriate and safe use of medicines

### The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) NHS Business Service Authority - NHSBSA)	0.63	0.60	0.94	Variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set).	7.8%	7.0%	8.7%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
(01/10/2017 to 30/09/2018) (NHSBSA)				

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes <sup>13</sup>
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes <sup>14</sup>
Explanation of any answers and additional evidence:	

Medicines management	Y/N/Partial
<p>13. Two medicines recommended for treating certain medical emergencies were not available during our inspection. These were injectable diclofenac (used to treat pain and inflammation) and an anti-emetic medicine (used to treat nausea). The provider explained these had been removed from the emergency medicines bag, as they had expired. The provider ensured these were available by the end of the inspection day.</p> <p>14. The practice had made improvements to their medicines stock management system, and were now checking and maintaining appropriate stocks of medicines, including vaccines. We reviewed these during our focussed follow up inspection in September 2018.</p>	



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

**The practice did not consistently learn and made improvements when things went wrong.**

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial <sup>15</sup>
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Partial <sup>16</sup>
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	15
Number of events that required action:	15
Explanation of any answers and additional evidence: 15. There continue to be inconsistencies in the recording of significant events. 16. We found examples of recent incidents which had not been captured as significant events, such as a child slipping in the toilet facilities leading to a head injury and the consultation room number 3 being out of use.	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
A prescription for a hormonal contraception was issued for a patient. During the regular reviews of uncollected prescriptions, it was noted that the patient had not collected this prescription. Patient was contacted and stated that she had not asked for this medication. Further investigation revealed that a patient with a similar name had requested this prescription	An apology was issued to the patient and on checking the medical record of the correct patient it was clear that she had already been given a prescription. All prescribers were reminded of the need to check that they were dealing with the correct patient and the admin and reception team were also reminded of this
Police alerts had been received about a patient who was vulnerable and at risk of abuse. The patient had been seen several times since then but this had not been discussed by the clinician. When it was noticed another clinician tried to contact the patient but the contact details on the patient medical record were wrong	Appropriate referrals were made by the Mental Health Team so the patient did not come to any harm. Practice had repeatedly tried to contact the patient by telephone and letter. Patient eventually made contact and was seen by a GP Ongoing review of all patients where safeguarding issues have been notified Any information that suggests that a patient is vulnerable is now treated as a priority and the patient's details are added to the vulnerable patient register, which is reviewed once a month

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence:	

## Effective

## Rating: Requires Improvement

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways were in place to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
Explanation of any answers and additional evidence:	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) (NHSBSA)	0.20	0.39	0.81	Significant Variation (positive)

### Older people

### Population group rating: Requires Improvement

Findings
<ul style="list-style-type: none"> <li>Older patients who are frail or may be vulnerable received holistic health assessment of their physical, mental and social needs.</li> <li>A dressings clinic was available at the practice, and was provided by their healthcare assistant.</li> <li>Seasonal flu vaccinations were provided to older people, and could also be provided at home to patients who had healthcare difficulties which prevented them from being able to attend the practice in person. Walk in flu vaccination appointments were available in the practice.</li> <li>People with caring responsibilities were identified and offered support by the practice. However, the practice had identified a relatively low proportion of their patient population with caring</li> </ul>

responsibilities.

- Multidisciplinary team (MDT) meetings were held in the practice to discuss and arrange the most appropriate care for people with complex needs. MDT meeting attendance included the community matron, district nurses, as well the practice's clinical team.
- The concerns we found in the provision of effective services affected all population groups, so we have rated all population groups as requires improvement.

## People with long-term conditions

## Population group rating: Requires Improvement

### Findings

- Seasonal flu vaccinations were provided to older people, and could also be provided at home to patients who had healthcare difficulties which prevented them from being able to attend the practice in person. Walk in flu vaccination appointments were available in the practice.
- Multidisciplinary team (MDT) meetings were held in the practice to discuss and arrange the most appropriate care for people with complex needs. MDT meeting attendance included the community matron, district nurses, as well the practice's clinical team.
- The practice's performance on quality indicators for long term conditions was in line with local and national averages. However, we noted the practice had relatively high exception reporting rates for several clinical areas: atrial fibrillation, coronary heart disease, depression, mental health, osteoporosis and cardiovascular disease – primary prevention. The practice explanation was that their records system had incorrectly categorised some patients as excepted, when they fell outside the QOF criteria.
- The concerns we found in the provision of effective services affected all population groups, so we have rated all population groups as requires improvement.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	72.2%	74.8%	78.8%	No statistical variation
Exception rate (number of exceptions).	13.0% (61)	7.5%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	74.9%	76.7%	77.7%	No statistical variation
Exception rate (number of exceptions).	6.8% (32)	6.8%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	72.4%	81.9%	80.1%	No statistical variation
Exception rate (number of exceptions).	7.0% (33)	7.9%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	71.8%	76.1%	76.0%	No statistical variation
Exception rate (number of exceptions).	2.0% (8)	2.1%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	92.8%	91.3%	89.7%	No statistical variation
Exception rate (number of exceptions).	0.7% (1)	5.7%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	77.4%	81.4%	82.6%	No statistical variation
Exception rate (number of exceptions).	6.8% (63)	3.3%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	85.7%	89.8%	90.0%	No statistical variation
Exception rate (number of exceptions).	15.5% (9)	6.2%	6.7%	N/A

#### Any additional evidence or comments

### Families, children and young people

### Population group rating: Requires Improvement

#### Findings

- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- However, childhood immunisation uptake rates were below the World Health Organisation (WHO) targets.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	111	125	88.8%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	105	121	86.8%	Below 90% minimum (variation negative)
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) (01/04/2017 to 31/03/2018) (NHS England)	106	121	87.6%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	108	121	89.3%	Below 90% minimum (variation negative)

#### Any additional evidence or comments

The practice had a call /recall protocol in place, which included for patients who were due childhood immunisations. The protocol had been recently updated in September 2018, and staff we spoke with could describe how they implemented it. We saw that the practice carried out monthly records searches for patients that were due immunisations, that records were maintained of patients that had been followed up, and that these were carried out in an appropriate and timely fashion.

#### Working age people (including those recently retired and students)

#### Population group rating: Requires Improvement

#### Findings

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- The concerns we found in the provision of effective services affected all population groups, so we have rated all population groups as requires improvement.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (PHE)	61.6%	66.0%	71.7%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	57.2%	60.8%	70.0%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	39.1%	40.5%	54.5%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	92.3%	73.1%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	48.1%	53.6%	51.9%	No statistical variation

#### Any additional evidence or comments

Some of cancer screening indicators, specifically breast and bowel cancer screening, for the practice were relatively lower than national averages. There were no active steps the practice was taking to increase uptake.

**Population group rating: Requires Improvement**

**People whose circumstances make them vulnerable**

#### Findings

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The concerns we found in the provision of effective services affected all population groups, so we have rated all population groups as requires improvement.



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

**Population group rating: Requires Improvement**

**Findings**

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The concerns we found in the provision of effective services affected all population groups, so we have rated all population groups as requires improvement.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	97.4%	92.2%	89.5%	No statistical variation
Exception rate (number of exceptions).	25.7% (27)	7.3%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	87.2%	91.9%	90.0%	No statistical variation
Exception rate (number of exceptions).	25.7% (27)	7.3%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	88.0%	82.5%	83.0%	No statistical variation
Exception rate (number of exceptions).	7.4% (2)	5.1%	6.6%	N/A

## Any additional evidence or comments

### Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	525.0	539.2	537.5
Overall QOF exception reporting (all domains)	4.7%	4.4%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Yes

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

<ul style="list-style-type: none"> <li>Clinical audit on the management of urinary tract infections (UTIs). The UTI audit led to the practice making changes to their antibiotic prescribing in the treatment of the condition, to adhere to published guidelines that was shown to have led to the best outcomes for patients.</li> </ul>
<ul style="list-style-type: none"> <li>The practice had carried out a cancer diagnosis audit, to check they had made appropriate referrals of suspected cases.</li> </ul>

### Any additional evidence or comments

QOF exceptions by clinical domain (2016 / 17). The practice reported particularly high exception rates in the following areas:

Clinical domain	Practice rate	CCG average	England Average
Atrial fibrillation	19%	6.9%	6.7%
Cancer	30.8%	22.8%	24.9%
Diabetes mellitus	10.8%	7.6%	11.4%
Dementia	16.7%	11.8%	10.1%
Depression	20%	26.2%	22.9%
Mental health	19.9%	6.4%	10.8%

QOF exceptions by clinical domain (2017 / 18). The practice reported particularly high exception rates in the following areas:

Clinical domain	Practice rate	CCG average	England Average
Atrial fibrillation	12.8%	5.1%	5.9%
Coronary heart disease	10.2%	8.8%	8.7%
Depression	17.2%	24.6%	22.8%
Mental health	23.5%	7.1%	11.0%
Osteoporosis	20.0%	15.6%	17.4%
Cardiovascular disease – primary prevention	33.3%	10.4%	24.8%

The practice stated that this was an issue with their clinical records system, and provided evidence in support of this. They had carried out an audit which showed that their records system categorised some patients as excepted, when they fell outside the QOF criteria. For example, for the Atrial fibrillation patient group, their audit found that they had exception reported one patient, which represented an exception reporting rate of 1.43%. For Depression, they did not exception report any patients.

## Effective staffing

**The practice could not demonstrate that staff had the skills, knowledge and experience to carry out their roles.**

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes <sup>1</sup>
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	No <sup>2</sup>
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	No <sup>3</sup>
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: 1. We saw improvements in the completing of the practice mandated staff training, although some gaps remained for some topics. 2. The practice employed healthcare assistant had not completed the Care Certificate. 3. Annual staff appraisals were overdue for the non-clinical staff. The practice management was aware of this and told us they planned to complete these during February 2019.	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or	Yes

organisations were involved.	
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A
Explanation of any answers and additional evidence:	

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
Explanation of any answers and additional evidence:	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	92.0%	94.5%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.6% (9)	0.5%	0.8%	N/A

### Any additional evidence or comments

--

## Consent to care and treatment

**The practice obtained consent to care and treatment in line with legislation and guidance.**

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Explanation of any answers and additional evidence:	

## Caring

## Rating: Requires Improvement

### Kindness, respect and compassion

**Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.**

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
Explanation of any answers and additional evidence:	

CQC comments cards	
Total comments cards received.	2
Number of CQC comments received which were positive about the service.	2
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC comments cards	Respondents said the practice was much improved, and that they care and listen.
Patient interviews	Patients we spoke with during our inspection told us they were treated with respect and compassion by the staff team and that the clinician listened to them and understood their issues.

## National GP Survey results

**Note:** The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
11056	419	103	24.6%	0.93%

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 (01/01/2018 to 31/03/2018)	76.2%	85.9%	89.0%	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 (01/01/2018 to 31/03/2018)	75.3%	83.3%	87.4%	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 (01/01/2018 to 31/03/2018)	87.8%	94.8%	95.6%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	61.6%	79.1%	83.8%	Variation (negative)



### Any additional evidence or comments

The practice had not actively acted in response to their results from the national GP survey. However, they told us they reviewed the results of the Friends and Family test (FFT) on an ongoing basis, and we saw that they posted the FFT results on their website. They gave the example of one healthcare professional being found to regularly take longer with patients in their appointments, and that this was discussed with the healthcare professional concerned and their appointments were now running in a more punctual manner.

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

### Any additional evidence

The practice was conducting its own inhouse patient survey during January 2019, which healthcare professionals invited patients to complete at the end of their consultations. At the time of our inspection they had received 7 completed surveys, which showed mixed levels of satisfaction in care and treatment experiences.

### Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
Explanation of any answers and additional evidence: Information was available on a noticeboard in the waiting area about community and advocacy services for people with caring responsibilities.	

Source	Feedback
Interviews with patients.	Patients we spoke with told us they felt as involved as they wanted to be in decisions about their care and treatment.

## National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	84.3%	91.2%	93.5%	Variation (negative)

### Any additional evidence or comments

The practice had not actively acted in response to their results from the national GP survey.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	No
Information about support groups was available on the practice website.	Yes
Explanation of any answers and additional evidence:	

Carers	Narrative
Percentage and number of carers identified.	70 people (0.6% of the patient population) had been identified as having caring responsibilities.
How the practice supported carers.	They were offered health checks, additional services such as flu vaccinations if they were eligible, were signposted to local services that may be able to offer further assistance.
How the practice supported recently bereaved patients.	The practice did not have any specific support arrangements in place for bereaved patients. However, information was available in the patient waiting area on local bereavement services.

## Privacy and dignity

### The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Yes

Consultation and treatment room doors were closed during consultations.	Yes
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes
Explanation of any answers and additional evidence:	

## Responsive

## Rating: Inadequate

### Responding to and meeting people's needs

#### The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Yes
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Yes
Explanation of any answers and additional evidence:	

Practice Opening Times	
Day	Time
Opening times:	
Monday	7:00am – 6:30pm
Tuesday	8:00am – 7:30pm
Wednesday	8:00am – 6:30pm
Thursday	8:00am – 6:30pm
Friday	8:00am – 6:30pm
Appointments available:	
Monday	7:00am – 6:30pm*
Tuesday	8:00am – 7:30pm*
Wednesday	8:00am – 6:30pm*
Thursday	8:00am – 6:30pm*
Friday	8:00am – 6:30pm*
*Appointments were available for three-hour sessions in the morning and afternoon. Appointments were not usually available between 12 and 2pm.	
Unlimited telephone slots fulfilled by the duty doctor.	
On the day of our inspection, we observed the following in relation to appointment availability: The next emergency appointments were available the following day from 11am, and there were 6 appointments. The practice had booked a locum GP for the following day in addition to the healthcare professionals already on duty, so additional routine appointments would be available during the day as well. Two additional three-hour GP sessions were made available on the Thursday and Friday.	

## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
11056	419	103	24.6%	0.93%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	88.2%	92.9%	94.8%	No statistical variation

### Any additional evidence or comments

## Older people

## Population group rating: Inadequate

### Findings

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- However, the concerns we found in the provision of responsive services affected all population groups, so we have rated all population groups as inadequate.

## People with long-term conditions

## Population group rating: Inadequate

### Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice liaised with multidisciplinary teams to discuss and manage the needs of patients with complex medical issues.
- However, the concerns we found in the provision of responsive services affected all population groups, so we have rated all population groups as inadequate.

## Families, children and young people

## Population group rating: Inadequate

### Findings

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.

- However, the concerns we found in the provision of responsive services affected all population groups, so we have rated all population groups as inadequate.

### **Working age people (including those recently retired and students)**

**Population group rating: Inadequate**

#### **Findings**

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours sessions were provided twice a week.
- Telephone consultation appointments were available throughout the week, which gave people increased flexibility in accessing the service.
- However, the concerns we found in the provision of responsive services affected all population groups, so we have rated all population groups as inadequate.

### **People whose circumstances make them vulnerable**

**Population group rating: Inadequate**

#### **Findings**

- The practice held a register of patients living in vulnerable circumstances including homeless people, and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- However, the concerns we found in the provision of responsive services affected all population groups, so we have rated all population groups as inadequate.

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

**Population group rating: Inadequate**

#### **Findings**

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- However, the concerns we found in the provision of responsive services affected all population groups, so we have rated all population groups as inadequate.

## Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Yes
Explanation of any answers and additional evidence:	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	41.2%	N/A	70.3%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	49.5%	62.1%	68.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	48.1%	61.2%	65.9%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	49.9%	65.8%	74.4%	Variation (negative)

#### Any additional evidence or comments

- The practice offered telephone consultations appointments daily as part of their services.
- The practice had changed to a new telephone system within the last year in response to patients and other services' feedback about the difficulties in getting through to the practice. However, they were yet to analyse or act on the feedback. They had not established whether that change had improved patient experience of accessing through the phone system.

Source	Feedback
Patient interviews	We spoke with 9 people during this inspection and received two comment cards.

	<p>Patients had plenty of time, good at listening, although a couple of people told us it depended on who they saw.</p> <p>Some patients still report experiencing difficulties getting through to the practice by telephone, and long waits</p>
--	--



## Listening and learning from concerns and complaints

**Complaints were listened and responded to and used to improve the quality of care.**

Complaints	
Number of complaints received in the last year.	9
Number of complaints we examined.	1
Number of complaints we examined that were satisfactorily handled in a timely way.	1
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	1

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes
Explanation of any answers and additional evidence: During our inspection we saw that feedback through comments and suggestions, and complaints were now being appropriately managed.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient was unhappy at the length of time that they had had to wait when attending for a pre-booked appointment.	<p>The practice manager investigated and discovered that the GP concerned had a patient booked into his routine surgery who was very ill and needed a hospital admission by ambulance. This delayed his surgery considerably. It was also clear that the Reception Team did not advise the patients who were waiting to see the GP, about this delay.</p> <p>The need to make patients aware of delays was reinforced during a Practice Meeting.</p>
Patient requested a prescription but this was not ready when they came to collect it. A second request was lost.	<p>The practice manager investigated but could not find a reason for the delay. Other prescriptions received at the same time had been processed in the usual manner.</p> <p>A GP prepared a new prescription whilst the patient waited. The patient met with the practice manager, and was asked to inform him when a next prescription was requested so that he could monitor the request.</p> <p>There was no clear log showing when prescriptions were received by the Practice so a log was started.</p>

## Well-led

## Rating: Inadequate

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence:	

### Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence:	

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	No <sup>1,2</sup>
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
Explanation of any answers and additional evidence: 1. The practice was behind on their schedule for completing staff appraisals. 2. There was no evidence of regular staff meetings being held in the practice. The practice manager informed us that they held monthly staff meetings, however they were unable to provide meeting minutes of these. Staff we spoke with also did not recall attend monthly meetings throughout the previous year.	

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

Source	Feedback
Staff interviews	The practice was behind on their schedule for completing staff appraisals. There was no evidence of regular staff meetings being held in the practice.

## Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Partial <sup>3</sup>
Explanation of any answers and additional evidence: 3. The practice premises were maintained by the building landlords. Lines of accountabilities and responsibilities for building maintenance and repairs were sometimes difficult to trace. For example, ongoing delays in addressing recent damage to one of the clinical rooms was made more complicated by the difficulties in identifying responsible parties.	

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial <sup>4</sup>
There were processes to manage performance.	Partial <sup>5</sup>
There was a systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial <sup>6</sup>
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: 4. There continues to be inconsistencies in the recording of significant events. We found examples of recent incidents which had not been captured as significant events. 5. The practice was behind on their schedule for completing staff appraisals. There were still gaps in staff training. 6. There was no evidence of regular staff meetings being held in the practice.	

## Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Partial <sup>7</sup>
There were effective arrangements for identifying, managing and mitigating risks.	Partial <sup>8</sup>
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence: 7. The practice informed us of discrepancies in exception reporting in the QOF results, where the exception reporting figures was much higher in the official submitted figures than their actual exception reported rates. 8. There continues to be inconsistencies in the recording of significant events. We found examples of recent incidents which had not been captured as significant events.	

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

**The practice did not involve the public, staff and external partners to sustain high quality and sustainable care.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial <sup>9</sup>
Staff views were reflected in the planning and delivery of services.	Partial <sup>10</sup>
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Partial <sup>11</sup>
Explanation of any answers and additional evidence: 9. The practice regularly collated and reviewed the results of friend and family test (FFT), and displayed these results on their website. For 2018, the monthly summaries showed an upward trend in patients stating they were extremely likely or likely to recommend Bermondsey Spa Medical Practice to Friends and Family, and a downward trend in patients stating they were unlikely or extremely unlikely to recommend the practice. 10. The practice did not hold regular staff meetings. Staff views were not sought in the planning and delivery of the service. 11. However, there was no evidence of the practice acting on the results of the GP patient surveys to improve services.	

Feedback from Patient Participation Group.

Feedback
The practice has faced an ongoing challenge to develop and maintain a patient participation group. They have sought external advice, have a poster campaign to try to recruit patients into the PPG and have facilitated meetings in August, September and November 2018, but the meetings had had few attendees.

### Any additional evidence

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial <sup>12</sup>
Learning was shared effectively and used to make improvements.	Partial <sup>13</sup>
Explanation of any answers and additional evidence:	
Examples of continuous learning and improvement	
12. The practice had identified a range of mandatory training topics it expected its staff team to complete on an on-going basis. However, there were gaps in staff training. 13. Clinical staff carried out quality improvement activities, in the form of clinical audits and in the review and action of FFT findings.	

## 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 Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	No statistical variation	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
6	No data	Null

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.
- 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.

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>

### Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease
- **PHE**: Public Health England
- **QOF**: Quality and Outcomes Framework
- **STAR-PU**: Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.