

Care Quality Commission

Inspection Evidence Table

Gorse Hill Medical Centre (1-583526759)

Inspection date: 21 January 2019

Date of data download: 08 February 2019

Overall rating: Inadequate

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

Safe

Rating: Inadequate

The practice was rated as inadequate for providing Safe services because:

Patients were at risk of harm because systems and processes were not sufficiently implemented to keep them safe.
Concerns were found around incident reporting, safeguarding, clinical record keeping, patient safety alerts, prescription protocols, emergency equipment, recruitment processes and information sharing.

Safety systems and processes

The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	N
There were policies covering adult and child safeguarding.	Partial
Policies took account of patients accessing any online services.	N
Policies and procedures were monitored, reviewed and updated.	Y
Policies were accessible to all staff.	N
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	N
There was active and appropriate engagement in local safeguarding processes.	N
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Partial

Safeguarding	Y/N/Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice could not demonstrate that all staff were up to date with safeguarding training at the required levels including the safeguarding lead. • There were no minutes of regular multidisciplinary safeguarding meetings and no evidence to substantiate that multi-disciplinary meetings or whole team safeguarding discussions took place. • There was no policy to follow up children who missed outpatient appointments even if they were on the child protection register. We found evidence where a child had missed an appointment and no action had been documented. • Staff could not easily demonstrate where they would access up to date policies and procedures. The safeguarding policy we were given was Trafford-wide. The practice did not provide a practice specific policy. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Partial
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	N
Staff had any necessary medical indemnity insurance.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was no evidence that appropriate checks for locum staff had been undertaken. There were no personnel files for the two locum GPs who had not come to work for the practice through an agency. One of the long term sessional GPs did not have a contract and did not consider themselves employed by the practice. • There was no system to check that health care staff were up to date with tetanus, polio, diphtheria, measles, mumps and rubella. • One of the nursing staff had recently returned from long-term sick and she told us she had returned to work on a phased basis. We were told by the registered manager that a personal development plan had been completed on her return but there was no evidence to support this. 	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test:	Y 08.01.2019
There was a record of equipment calibration. Date of last calibration:	Y 08.01.2019
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Not asked for
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check:	Y January 2019
There was a log of fire drills. Date of last drill:	N* 16.10.2018
There was a record of fire alarm checks. Date of last check:	N
There was a record of fire training for staff. Date of last training:	N
There were fire marshals.	N
A fire risk assessment had been completed. Date of completion:	Y 18.10.2018
Actions from fire risk assessment were identified and completed.	NA
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Two members of staff we spoke to did not have any recollection of fire alarm checks taking place and said they had not heard the fire alarm being tested on a weekly basis, nor did they know when it should be carried out. There was no evidence of fire training in-house although training was available via the electronic training system that had been introduced. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	Y* 26.09.18
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Y* 26.09.18
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> One of the site administrators undertook the health and safety risk assessments. There were no actions identified on the last assessment. During the inspection we found loop chords on window blinds which should have been identified as a potential risk to patients. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not fully met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y*
Staff had received effective training on infection prevention and control.	Y
Date of last infection prevention and control audit:	15.01.2019
The practice had acted on any issues identified in infection prevention and control audits.	N
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">The clinical staff member we spoke with about infection control was not the infection control lead and was not aware who was the lead for the practice. They told us their role was just to make sure everything was clean.The infection control audit was carried out by Trafford CCG. There was an action at Gorse Hill site to replace the bath with a deep sink unit to facilitate the decontamination and disinfection of domestic cleaning equipment (which was done in the bathroom which was also the staff toilet). This was an ongoing action over a number of years that had not been completed because (we were told) the practice was expecting to move into new premises.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	N
Risk management plans for patients were developed in line with national guidance.	N
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y*
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Partial
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or another clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line	Y

with National Institute for Health and Care Excellence (NICE) guidance.	
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice could not demonstrate that comprehensive risk assessments were carried out for all patients. One of the GPs did not document appropriate patient consultations. Patients on high risk medicines received repeat prescriptions with evidence of ineffective blood monitoring. There was no evidence of any internal discussions or formal training on sepsis and no protocol in place. Staff we spoke to said they knew what to do in an emergency and would call for a clinician. Basic life support training had been completed. 	

Information to deliver safe care and treatment

Staff did not have all the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y*
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Partial
Referral letters contained specific information to allow appropriate and timely referrals.	Y*
Referrals to specialist services were documented.	Partial
There was a system to monitor delays in referrals.	Partial
There was a documented approach to the management of test results and this was managed in a timely manner.	N
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.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> There was a back log of patient records requiring summarising and we were told the CCG were assisting the practice with this task which was a Trafford initiative to help all practices. The systems to share information with internal staff were not effective. One of the GPs had never accessed their NHS mail. Not all patient consultations were appropriately documented. The referral letters that we saw were appropriately actioned. 	

- One of the GPs we spoke to said that they monitored their own referrals to ensure they had been appropriately attended or actioned, specifically for two week waits. However, they did not follow a specific internal protocol and did not know if one existed.
- We found many test results that had not received appropriate and necessary action.
- There was no evidence to support consistent communication between all GPs or all services about patients using multiple services.

Appropriate and safe use of medicines

The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) (NHS Business Service Authority - NHSBSA)	1.03	1.01	0.94	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2017 to 30/09/2018) (NHSBSA)	9.5%	13.1%	8.7%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2018 to 30/09/2018) (NHSBSA)	5.35	5.46	5.64	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2018 to 30/09/2018) (NHSBSA)	1.58	2.41	2.22	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Partial
Blank prescriptions were kept securely and their use monitored in line with national	Partial

Medicines management	Y/N/Partial
guidance.	
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y*
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.	NA
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	No
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Not asked
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.	N
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We found medicines that were not monitored at both sites. For example, we identified Tramadol in one of the GPs drawers which is a high risk medicine known as a controlled drug. Blank prescriptions were accessible to cleaning staff when the practice was closed. The serial numbers and location of prescriptions were not monitored effectively. We saw that an acute prescription for a controlled drug was authorised by an administrator. We were told the GP would have agreed this and it would have been checked before it was signed but there was no evidence in the patient record) to demonstrate that a clinician had authorised. 	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> Patients signed for prescriptions of controlled drugs on collection. There was no defibrillator on site and no risk assessment for the rationale of this decision safety of patients in an emergency. This was an action highlighted at the inspection in 2016. We found a Patient Group Direction (PGD) that was unsigned by nurses or a GP. 	

Track record on safety and lessons learned and improvements made

There was no system in place and the practice could not demonstrate that it learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	N
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	N
Staff understood how to raise concerns and report incidents both internally and externally.	Partial
There was evidence of learning and dissemination of information.	N
Number of events recorded in last 12 months:	2*
Number of events that required action:	2
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice told us about safety mechanisms they were planning to implement but there was no evidence of previous safety monitoring and we found areas of concern that had not been documented or discussed with the whole team to prevent reoccurrence in the future. Staff told us they knew what to do in the event of an incident and said they would raise and report concerns but there was no evidence of a system for doing this. *The registered manager presented two significant incidents that had been written up for the benefit of the inspection. Significant incidents were an agenda item on minutes of staff meetings but these incidents were not documented as having been discussed. There was no evidence that the incidents had been revisited to complete the cycle and ensure that learning had been achieved. The persons involved had not been invited to the initial review. 	

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

Event	Specific action taken
Incorrect travel vaccine administered by locum practice nurse identified when the patient registered at another practice. The other practice emailed Gorse Hill to let them know the error.	To discuss with staff the SEA raised and ensure full understanding (no documented evidence of this being discussed at meetings). Ensure that no further travel vaccines booked in with that clinician until they had been on an update course
Power Outage	Appropriate cold chain management administered. Cool

	boxes obtained in case of reoccurrence.
--	---

Safety alerts		Y/N/Partial
There was a system for recording and acting on safety alerts.		N
Staff understood how to deal with alerts.		N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We were advised that safety alerts were received and disseminated by email to all staff for action. • We identified a search of all women of child bearing age, who were taking sodium valproate had been conducted but we could find no systematic notification of patients of the risk of taking this medication. For example, one patient despite presenting with significant ongoing risk and attendance at the surgery, had no documentation of any discussion taking place. • We found that the lead GP did not access their NHS mailbox and the business manager was not aware of this. • We found safety alerts about medicines where appropriate action had either not been taken, or was not documented as having been taken. 		

Effective

Rating: Inadequate

The practice was rated as inadequate for providing Effective services because:

Recruitment and training checks on staff were not sufficient to ensure that necessary information was up to date.

Local and national guidelines were not always adopted and there was no proactive monitoring or quality control processes other than QOF

Internal tasks, patient consultations and call and recall processes were not effective.

These issues impacted across all population groups which as a result were all rated inadequate.

Effective needs assessment, care and treatment

Patients' needs were not always assessed and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
We saw evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways in place to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Each clinician worked in silo and according to their own knowledge base. There was nothing to demonstrate that all clinicians worked according to practice protocols or that practice protocols were in place.When patients from the branch surgery at Ayres Road tried to make appointments at Gorse Hill staff were instructed to tell them that was not an option.We reviewed clinical records where there was evidence that patients had not been reviewed and updated in a timely manner.	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic Group	1.30	0.89	0.81	No statistical variation

Prescribing	Practice performance	CCG average	England average	England comparison
Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) <small>(NHSBSA)</small>				

Older people

Population group rating: Inadequate

Findings
<p>The issues identified in the Effective domain impacted all population groups. In addition, we found:</p> <ul style="list-style-type: none"> • The practice used a clinical tool within the clinical system to identify older patients who were living with moderate or severe frailty. • A screening tool was in place to identify patients with dementia. • Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. • Health checks were offered to patients over 75 years of age.

People with long-term conditions

Population group rating: Inadequate

Findings
<p>The issues identified in the Effective domain impacted all population groups. In addition, we found:</p> <ul style="list-style-type: none"> • The practice offered long duration clinics (20 minutes) for chronic disease management. When we reviewed those clinics, we saw that each patient was booked in at 10-minute intervals and each patient was told that they would probably have to wait, depending on how long the patient before them took. • Patients with long term conditions were reviewed but we did not see an effective call and recall system in place. We found that some patients on high risk medicines received repeat prescriptions with evidence that their bloods had not been appropriately checked or monitored • Staff responsible for reviews of patients with long-term conditions had received specific training but there was no system to monitor and check competencies for example when staff returned from long term sick. • One of the exception rates for diabetes was more than 50% higher than average.

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	84.8%	84.0%	78.8%	No statistical variation

64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	21.3% (105)	10.8%	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)	84.7%	77.3%	77.7%	No statistical variation
Exception rate (number of exceptions).	8.3% (41)	8.6%	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)	79.8%	81.8%	80.1%	No statistical variation
Exception rate (number of exceptions).	12.4% (61)	13.1%	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)	80.4%	77.1%	76.0%	No statistical variation
Exception rate (number of exceptions).	0.4% (2)	5.9%	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)	95.8%	93.0%	89.7%	No statistical variation
Exception rate (number of exceptions).	8.9% (7)	11.7%	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	86.8%	84.1%	82.6%	No statistical variation

31/03/2018) (QOF)				
Exception rate (number of exceptions).	2.9% (23)	3.5%	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)	93.2%	89.1%	90.0%	No statistical variation
Exception rate (number of exceptions).	2.2% (1)	6.0%	6.7%	N/A

Any additional evidence or comments

We also found:

- The practice could demonstrate how they identified patients with commonly undiagnosed conditions such as diabetes.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

Families, children and young people

Population group rating: Inadequate

Findings

The issues identified in the Effective domain impacted all population groups. In addition, we found:

- Childhood immunisation uptake rates were not all in line with the World Health Organisation (WHO) targets. The practice had recently identified several children who had not received the MMR immunisation.
- The arrangements to identify and review the treatment of women of child bearing age on long-term medicines was not effective. We found evidence of two patients that were not provided with advice and in accordance with best practice guidance.
- There was no system follow up failed attendance of children's appointments following an appointment in secondary care or for immunisation. We found evidence of two patients that were not followed up appropriately.

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	53	54	98.1%	Met 95% WHO based target (significant variation positive)

DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)				
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)	59	65	90.8%	Met 90% minimum (no variation)
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)	58	65	89.2%	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)	60	65	92.3%	Met 90% minimum (no variation)

Any additional evidence or comments

We also found:

- Young people could access services for sexual health and contraception.
- All children were seen on the day if required

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

The issues identified in the Effective domain impacted all population groups. In addition, we found:

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was 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.

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	65.9%	76.9%	71.7%	No statistical variation

aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)				
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	54.9%	70.3%	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)	39.8%	57.1%	54.6%	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)	70.0%	77.0%	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)	35.3%	47.0%	51.9%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

The issues identified in the Effective domain impacted all population groups. In addition, we found:

- The practice held palliative care list. The palliative care lead GP told us that end of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- There were no routine multi-disciplinary meetings taking place.
- We reviewed the records of two patients identified as palliative care. There was no care plan, no alert on the notes and no Do Not Attempt Resuscitation (DNAR) form.
- We were told that patients would not be aware that they were on a palliative care list. Patients with multi-morbidities were coded as palliative care but no action was taken. The palliative care lead said they felt they needed more training.
- There was no register of patients living in vulnerable circumstances including homeless people, travellers or those with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

The issues identified in the Effective domain impacted all population groups. In addition, we

found:

- 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.
- Not all staff had received dementia training.
- Patients were encouraged to wean off high risk medicines. Prescriptions were signed for when collected.

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) (QOF)	93.2%	93.0%	89.5%	No statistical variation
Exception rate (number of exceptions).	2.7% (2)	8.8%	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) (QOF)	91.5%	92.0%	90.0%	No statistical variation
Exception rate (number of exceptions).	5.3% (4)	8.0%	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) (QOF)	70.8%	81.8%	83.0%	No statistical variation
Exception rate (number of exceptions).	7.7% (2)	6.0%	6.6%	N/A

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	559.0	551.7	537.5
Overall QOF exception reporting (all domains)	9.0%	5.0%	5.8%

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

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

- Improvement in uptake of cervical smears (initiated by the CCG who identified concern).
- Improvement in prescribing of antibiotics benzodiazepines and hypnotics (initiated by the CCG who identified concern).

Any additional evidence or comments

*The practice told the inspection team that it had started a new project on quality improvement programmes initiated by the partners to deal with clinical and non-clinical areas. We were told that they were audited and actioned on a regular basis. There was no evidence of regular audit and action and no issues identified.

Effective staffing

The practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	N
The learning and development needs of staff were assessed.	N
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Partial
There was an induction programme for new staff.	Unknown
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	NA
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N
Explanation of any answers and additional evidence:	

- The palliative care lead felt they needed more training in this area.
- The system to monitor training and development such as safeguarding and palliative care, was not effective.
- Competencies were not monitored and reviewed.
- Sessional GPs did not undertake appraisal within the practice and learning needs were not discussed.
- Clinical, sessional and locum GP staff worked in isolation.

Coordinating care and treatment

Staff did not work 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.	N
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y*
Patients received consistent, coordinated, person-centred care when they moved between services.	Y*
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	NA
Explanation of any answers and additional evidence: *This answer was generated from QOF external data. We found on inspection there were no multidisciplinary safeguarding meetings and no palliative care meetings taking place. *We were told that care was delivered and reviewed with different services and teams.	

Helping patients to live healthier lives

Staff helped patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y

Staff discussed changes to care or treatment with patients and their carers as necessary.				Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.				Y
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)	96.7%	95.3%	95.1%	No statistical variation
Exception rate (number of exceptions).	1.2% (16)	0.6%	0.8%	N/A

Consent to care and treatment

The practice demonstrated that consent to care and treatment was obtained in line with legislation and guidance.

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

Caring

Rating: Requires Improvement

Kindness, respect and compassion

Staff mostly treated patients with kindness, respect and compassion. Feedback from patients was sometimes negative about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y*
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: *The practice wanted all patients to use English even if this was not their first language. We found that the lead GP worked hard to try to accommodate the needs of all the patients registered at the practice over both sites. They worked from home at the weekends making phone calls and speaking to patients about their care and treatment. However, many of those consultations were not documented in the patients' records and it was not possible to quantify this.	

CQC comments cards	
Total comments cards received.	42
Number of CQC comments received which were positive about the service.	40
Number of comments cards received which were mixed about the service.	2
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Patient	A patient was disappointed with the way they were treated at the practice.
Staff	We saw staff speak to patients politely.
Patient Group	Privacy is not maintained at reception.
Inspection team	We observed privacy was not maintained at reception.

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
6147	423	91	21.5%	1.48%

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)	81.7%	90.3%	89.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018)	83.9%	88.5%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	88.1%	96.4%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	70.7%	86.0%	83.8%	No statistical variation

Any additional evidence or comments

Although there was no statistical variation all the indicators above were lower than the CCG and national averages.

Question	Y/N
The practice had carried out its own patient survey/patient feedback exercises via their patient participation group.	Y

Involvement in decisions about care and treatment

Staff said they 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.	Partial
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: * We were told that many staff could speak the various languages of the patients but the practice was trying to encourage all patients to use one language (English).	

Source	Feedback
Interviews with patients.	Patients we spoke with were very happy with 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)	79.0%	94.1%	93.5%	Variation (negative)

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	N
Information about support groups was available on the practice website.	Y*
Explanation of any answers and additional evidence: *There was no information about bereavement or carer support on the website. *Some services and clinic information on the website were not in English. *Family members (including children) were encouraged to interpret for those who didn't speak English. *We were told that many staff could speak the various languages of the patients but the practice was trying to encourage all patients to use one language (English).	

Carers	Narrative
--------	-----------

Percentage and number of carers identified.	132 carers were identified which was 2% of the practice population
How the practice supported carers.	Carers were offered NHS checks and free influenza vaccinations
How the practice supported recently bereaved patients.	Bereaved patients received support and advice from the practice if they needed it.

Privacy and dignity

The practice did not always respect patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	N
<p>Explanation of any answers and additional evidence:</p> <p>Patients we spoke with and members of the PPG reported that privacy was an issue at reception and conversations could be overheard. There was an electronic booking in system but we were told that patients still came to the window to book in. The practice was aware of the privacy concern and had asked for funding to make improvements. That funding had been refused.</p> <p>Nothing had been done by the practice to reduce the problem.</p>	

Responsive

Rating: Inadequate

Responding to and meeting people's needs

Services did not meet patients' needs.

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	N
The practice made reasonable adjustments when patients found it hard to access services.	Partial
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.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The premises were not compliant with the Disability Discrimination Act.• Patients in wheelchairs could not access the premises – those patients were seen at home• There was no formal process in place to discuss and manage end of life and patients were dealt with on a case by case basis.	

Practice Opening Times Gorse Hill	
Day	Time
Opening times:	
Monday	8.00am to 6.30pm
Tuesday	8.00am to 6.30pm
Wednesday	8.00am to 6.30pm
Thursday	8.00am to 6.30pm
Friday	8.00am to 6.30pm
Appointments were available with different GPs at various times during each day between 8am and 6.30pm	
Extended hours were available until 8pm on Mondays and Tuesdays	

Practice Opening Times Ayres Road	
Day	Time

Opening times:	
Monday	8.00am to 6.30pm
Tuesday	8.00am to 6.30pm
Wednesday	8.00am to 6.30pm
Thursday	8.00am to 6.30pm
Friday	8.00am to 6.30pm
Emergency and Telephone Appointments available:	
Monday	11.00am to 1.30pm variable
Tuesday	11.00am to 1.30pm variable
Wednesday	11.00am to 1.30pm variable
Thursday	11.00am to 1.30pm variable
Friday	11.00am to 1.30pm variable
Appointments were available with different GPs at various times during each day between 8am and 6.30pm	

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
6147	423	91	21.5%	1.48%

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)	87.5%	96.0%	94.8%	No statistical variation

Any additional evidence or comments

Older people

Population group rating: Inadequate

Findings

The issues identified in the Responsive domain impacted all population groups. In addition, we found:

- All patients had a named GP who supported them in whatever setting they lived.
- The practice offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The GPs responded to the religious and cultural observances and beliefs of some patients such as when a death certificate was required to enable prompt burial in line with families' wishes.

People with long-term conditions

Population group rating: Inadequate

Findings

The issues identified in the Responsive domain impacted all population groups. In addition, we found:

- Patients with multiple conditions could have their needs reviewed in one appointment. The appointments were advertised as longer appointments but patients were booked in at ten-minute intervals and then were told that they may have to wait if the person before them took longer than expected.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services on a case by case basis.

Families, children and young people

Population group rating: Inadequate

Findings

The issues identified in the Responsive domain impacted all population groups. In addition, we found:

- There was no system 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. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

The issues identified in the Responsive domain impacted all population groups. In addition, we found:

- The practice had not adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Although Ayres Road purported to be a branch surgery and we were told that patients could attend either surgery, there was evidence in meeting minutes that staff were advised to tell patients from Ayres Road that they could not be seen at Gorse Hill.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

The issues identified in the Effective domain impacted all population groups. In addition, we found:

- The practice could identify the number of patients living in vulnerable circumstances including those with a learning disability. However, there were no working registers that were reviewed and discussed.

People experiencing poor mental health (including those with dementia)

Population group rating: Inadequate

Findings

The issues identified in the Responsive domain impacted all population groups. In addition, we found:

- Priority appointments could be provided when necessary to those experiencing poor mental health.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

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.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when necessary.	Partial
On the day of the inspection a patient had their appointment changed twice and was asked to return to the practice at a later time in the day due to the CQC inspection.	

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)	75.9%	N/A	70.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	53.9%	71.3%	68.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or	52.2%	67.4%	65.9%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)				
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)	54.5%	75.5%	74.4%	No statistical variation

Any additional evidence or comments

Although there is no statistical variation all but one of the indicators above are lower than the local and CCG average.

Source	Feedback
For example, NHS Choices	Comments on NHS choices were positive

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.	4
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	4
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Example(s) of learning from complaints.

Complaint	Specific action taken
A person complained about a prescription not being processed correctly for a travel vaccine.	The practice responded to the patient appropriately, apologised and arranged for the prescription cost to be refunded.
Patients complained about the attitude of reception staff when discussing matters over the telephone.	The matter was discussed with the reception staff and role play scenarios took place to help reception staff respond more appropriately during difficult conversations.

Well-led

Rating: Inadequate

The practice was rated as inadequate for providing well led services because:

- Overall leadership across the practice was ineffective. Arrangements for identifying, monitoring, recording and managing risks did not meet the standards to ensure safe and effective care.
- Overall governance arrangements were not satisfactory.
- Practice leaders did not demonstrate awareness of potential issues within the practice.
- Previous improvements had not been sustained.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The leaders did not demonstrate that appropriate systems were in place to manage and oversee the clinical or day to day performance of the practice to ensure safe working.• Leadership across the practice was ineffective.• Leaders were not knowledgeable about issues and priorities relating to the quality and future of services.• Leaders did not demonstrate that they were fully aware of the regulatory requirements of the Health and Social Care Act 2014• Challenges were understood but were not being addressed in a consistent manner because the practice was waiting for action from the CCG.• Staff at the practice worked in silo with limited oversight and clinical supervision.	

Vision and strategy

The practice had a clear vision but it was not supported by a 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.	Partial

There was a realistic strategy to achieve their priorities.	N
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Not all staff were aware of any vision and strategy for the practice. The registered manager had a vision to provide all out of hours access by this practice from the Ayres Road location but at the time of the inspection no formal discussions had been had with the CCG. 	

Culture

The practice culture did not effectively support high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	N
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff felt they were delivering high quality care and treatment. There was no formal evidence of regular monitoring to corroborate that high quality sustainable care was being achieved. There was often only one female GP and one female receptionist working at the practice in the evening without a specific protocol about lone/safe working. 	

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

Source	Feedback
Practice Staff	Staff were mostly complimentary about working at the practice and said they were happy there. Some staff did not ever see or communicate with any of the other employees if they did not physically work with them.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Structures, processes and systems to support good governance and management were not clearly set out, understood, monitored or effective. There were policies in place but they were poorly organised. Not all policies were easily accessible in one consistent place. Some policies were duplicated, some not reviewed, some did not contain practice-specific information and some were missing. 	

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.	N
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Unknown
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> There was no effective process to identify, understand, monitor and address current and future risks including risks to patient safety. The practice was not pro-active in identifying the risks that could occur. There was no documented action plan or protocol in place for staff to follow in the event of a patient emergency. 	

Appropriate and accurate information

Not all staff used data and information proactively to drive and support decision making. The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Unknown
Our inspection indicated that information was accurate, valid, reliable and timely.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
Staff whose responsibilities included making statutory notifications understood what this entails.	Unknown
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Not all staff had access to appropriate clinical information because appropriate clinical information was not always documented on patient records. • There was evidence that information was not acted on in a timely and reliable manner. For example, tasks were not completed or monitored. • The inspection team found risks that had not been identified by the practice. 	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	No evidence
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
We were told that the practice listened to their patients and acted on information to improve services, but we saw that no action was taken about the privacy issues at reception.	
There was no evidence of any changes that had been made because of information from staff other than the partners.	

Feedback from Patient Participation Group (PPG).

Feedback
Patients in the group were happy with the practice Complaints were not discussed at the PPG. Members were asked for their comments for improvement Small improvements could be made – for example, there was no pen by the suggestion box for patient comments. The PPG had noticed that the premises were not DDA compliant Group feels care is going well for local people

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.	N
Learning was shared effectively and used to make improvements.	N
<p>Explanation of any answers and additional evidence:</p> <p>We were told of quality improvement plans that were in place. A new project on quality improvement programmes had been initiated to deal with clinical and non-clinical areas. We were told that those areas were being audited and actioned on a regular basis. There was no evidence of regular audit or action and no issues identified.</p> <p>There was no evidence that learning was shared effectively. Most information was disseminated by email or telephone. One of the GPs did not use their email inbox which was not known by the business manager.</p>	

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for most 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.