

# Care Quality Commission

## Inspection Evidence Table

### Carnarvon Medical Centre (1-5584372381)

Inspection date: 14 October 2019

Date of data download: 30 October 2019

## Overall rating: Requires Improvement

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

### Safe

### Rating: Inadequate

We previously inspected the practice on 20 November 2018 and rated it as requires improvement for providing safe services. When we inspected on 14 October 2019 to check if the required improvements had been made, we rated it as inadequate for providing safe services. We found that not all of the concerns had been addressed from the previous inspection and in addition, new breaches of regulations were found. Not all staff had received a disclosure and barring system (DBS) check, including some staff who had completed chaperone training. This was an issue at the last inspection.

On the day of inspection we found that there was no child or adult safeguarding policy in place which was specific to the practice; there was no recruitment policy or procedure in place and staff files were inconsistent; staff vaccination was not maintained in line with current Public Health England (PHE) guidance; health and safety checks of the premises were unclear, and records were incomplete; reviews following a significant event did not ensure that measures were put in place to reduce the likelihood of recurrence; there was no formal induction for new staff; not all staff had received training on infection prevention and control and there was evidence that not all staff who acted as chaperones had attended chaperone training.

#### 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.	P
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	N
There were policies covering adult and child safeguarding which were accessible to all staff.	N
Policies took account of patients accessing any online services.	N
Policies and procedures were monitored, reviewed and updated.	N

Safeguarding	Y/N/Partial
Partners and staff were trained to appropriate levels for their role.	P
There was active and appropriate engagement in local safeguarding processes.	N
The Out of Hours service was informed of relevant safeguarding information.	N
There were systems to identify vulnerable patients on record.	N
Disclosure and Barring Service (DBS) checks were undertaken where required.	N
Staff who acted as chaperones were trained for their role.	N
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.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>There was no evidence of who the named safeguarding lead was for the practice. On the day of inspection when staff were asked, they were not clear who it was.</li> <li>There was no safeguarding policy or procedure in place which was specific to the practice. There was a generic child protection procedure on file which had been due for review in August 2019. Staff were not aware of this and the document was not accessible to them. Staff we spoke to were not clear on safeguarding procedures. Immediately after the inspection, we saw evidence of a revised safeguarding children policy, but no evidence that this had been disseminated to staff.</li> <li>There was no Disclosure and Barring System (DBS) policy or procedure in place. On the day of inspection, we saw evidence that seven staff had received DBS checks in January 2019. However, some staff did not have a DBS check, including chaperones, and there was no procedure or any risk assessments in place to mitigate these decisions.</li> <li>There was no system for oversight of what training staff had attended and when refresher training was due. There was evidence that not all staff who acted as chaperones had attended chaperone training.</li> </ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	N
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>There was no recruitment policy or procedure in place and staff files were inconsistent. The same set of documents was not present in each file, for example, not all files contained training</li> </ul>	

certificates.

- Immunisation information was not kept centrally. On the day of inspection, we saw evidence that thirteen of the sixteen clinical and non-clinical staff had been asked to complete a form detailing their immunisations, but this had only been completed by five staff. Immediately after the inspection we saw that some staff had been sent a reminder to complete the form.

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: January 2019	Y
There was a record of equipment calibration. Date of last calibration: January 2019	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	N
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: October 2018	Y
There was a log of fire drills. Date of last drill: 31 July 2019	Y
There was a record of fire alarm checks. Date of last check: Each Friday - unverified	N
There was a record of fire training for staff. Date of last training: No definite date available but possibly after March 2019. Unverified.	N
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: April 2018	Y
Actions from fire risk assessment were identified and completed.	N/A
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The fire procedure notice for the practice was displayed on the wall of the reception area.</li> <li>• The practice shared a purpose-built building with two other practices and other healthcare services. Some of the safety health and safety checks and records were monitored and recorded by a central team. The practice was unable to confirm when checks had taken place and if any risks were identified or if any actions were required.</li> <li>• There were no risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. However, this was because the cleaning was carried out by an external company who had their own policies and procedures.</li> <li>• We were not satisfied that the practice complied with the relevant health and safety regulations.</li> </ul>	

Health and safety	Y/N/Partial
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Premises/security risk assessment had been carried out. Date of last assessment: Unknown	N
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Unknown	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The above assessments were conducted centrally for the building as a whole and the practice was unable to confirm if or when they had been carried out.</li> </ul>	

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	P
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 1 October 2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	N/A
There was a system to notify Public Health England of suspected notifiable diseases.	Y
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"> <li>Evidence showed that some, but not all staff had received training on infection prevention and control.</li> </ul>	

## 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.	Y
There was an effective induction system for temporary staff tailored to their role.	P
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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.	Y

There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>There was no formal induction procedure, but staff we spoke to told us that they received informal induction training from other staff members.</li> </ul>	

## 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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
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.	Y

## 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) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.87	0.97	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2018 to 30/06/2019) (NHSBSA)	14.2%	11.3%	8.6%	Variation (negative)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019)	5.58	6.31	5.63	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
(NHSBSA)				
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019)	1.00	1.09	2.08	Variation (positive)
(NHSBSA)				

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
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.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
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
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

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

### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	P
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	N
Number of events recorded in last 12 months:	3
Number of events that required action:	3
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Prior to the inspection, we saw a list of three significant events. However, these were not dated and we saw no evidence that they had been discussed at staff meetings. There was no timescale for actions and we saw no evidence that actions had been monitored or completed.</li> </ul>	

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

Event	Specific action taken
Hospital letters had been seen by a clinician, but information needed for action was not marked as well as could be. This was not picked up by prescribing and coding staff.	A meeting was held with all concerned. Clinicians agreed to make sure they mark letters for action. Staff were told to speak to clinicians if they were not sure of what action to take.
Vaccines were not put in fridge when delivered.	Manufacturers were contacted to find out protocol and how long vaccines could safely be left out of the fridge. A staff meeting was held and a new policy was put in place.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>We saw examples of actions taken on recent alerts, including sodium valproate.</li> </ul>	



## Effective

## Rating: Requires Improvement

Training records were incomplete and there was no oversight or monitoring. For example, records did not assure us that all staff had attended infection control training or appropriate safeguarding training. This impacted on all of the population groups. The performance indicators for patients with diabetes showed negative performance over time, with no plan in place for improvement. The data for two of the childhood immunisation indicators were below target for the year 2018/2019 and were also below target for the previous year 2017/2018, with no plan in place for improvement. The performance data for cancer indicators was below national averages for all five indicators and was below both local and national averages for four out of the five indicators. The data for cervical screening was also below local and national averages for 2018/19 and for the previous year, 2017/2018.

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y

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) (01/07/2018 to 30/06/2019) (NHSBSA)	1.57	1.35	0.75	Tending towards variation (negative)

### Older people

**Population group rating: requires improvement**

## Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

## People with long-term conditions

## Population group rating: requires improvement

## Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Some staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with a long term condition could be referred to a community team for assessment to provide care and treatment to avoid hospital admission.

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	60.8%	74.5%	79.3%	Variation (negative)
Exception rate (number of exceptions).	3.2% (11)	7.7%	12.8%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	75.8%	72.1%	78.1%	No statistical variation
Exception rate (number of exceptions).	3.8% (13)	8.6%	9.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	68.2%	72.5%	81.3%	Variation (negative)
Exception rate (number of exceptions).	6.4% (22)	11.1%	12.7%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	74.2%	75.6%	75.9%	No statistical variation
Exception rate (number of exceptions).	3.0% (11)	3.7%	7.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	95.5%	90.0%	89.6%	No statistical variation
Exception rate (number of exceptions).	27.3% (33)	9.1%	11.2%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	72.9%	80.8%	83.0%	Variation (negative)
Exception rate (number of exceptions).	2.0% (18)	4.3%	4.0%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	87.3%	92.1%	91.1%	No statistical variation
Exception rate (number of exceptions).	3.1% (2)	3.7%	5.9%	N/A

Any additional evidence or comments
<ul style="list-style-type: none"> <li>The indicator for 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 (01/04/2018 to 31/03/2019) has shown a negative variation for the last three years.</li> </ul>

- The indicator for 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 (01/04/2018 to 31/03/2019) has shown a negative variation for the last three years.
- The indicator for the percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) has shown a negative variation for the last two years, although 2018/19 has shown an improvement on 2017/18.

## Families, children and young people

## Population group rating: requires improvement

### Findings

- The practice has not met the minimum 90% target for two of four childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of four childhood immunisation uptake indicators.
- The practice followed up failed attendance of children's appointments on an adhoc basis.
- A social worker worked from the practice one day a week for staff to raise any safeguarding concerns.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	50	54	92.6%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	45	52	86.5%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	46	52	88.5%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles,	47	52	90.4%	Met 90% minimum

mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)				
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Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

### Any additional evidence or comments

- The practice was aware of the performance data relating to childhood immunisations, but we saw no evidence of action to improve this.
- The data for the two indicators which were below target (see above), for the year 2018/2019 were also below target for the previous year 2017/2018.

### 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 order repeat medication without the need to attend the surgery.
- Extended hours appointments were available.

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) (Public Health England)	63.2%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	60.1%	62.9%	72.1%	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)	45.0%	49.7%	57.3%	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)	17.6%	59.5%	69.3%	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)	47.8%	46.7%	51.9%	No statistical variation

### Any additional evidence or comments

- The performance data for cancer indicators was below national averages for all five indicators and was below both local and national averages for four out of the five indicators.
- The data for cervical screening, (as above), was also below local and national averages for the previous year, 2017/2018.
- A new member of staff had recently been appointed and we were told that one of her priorities was to improve this data.
- We were told that there were plans to visit a local mosque with the aim of educating community leaders of the importance of cervical screening.

## People whose circumstances make them vulnerable

## Population group rating: requires improvement

### Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- Staff were able to refer patients to a local complex care service to assist them with managing medication and to refer them to other local services to keep them safe.

## 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.
- Same day and longer appointments were offered when required.
- 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.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and	95.8%	91.4%	89.4%	No statistical variation

other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>				
Exception rate (number of exceptions).	4.0% (2)	14.7%	12.3%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	95.8%	93.2%	90.2%	No statistical variation
Exception rate (number of exceptions).	4.0% (2)	10.2%	10.1%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	85.2%	86.6%	83.6%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	6.8%	6.7%	N/A

## 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)	516	No Data	539.2
Overall QOF score (as a percentage of maximum)	92.3%	No Data	96.4%
Overall QOF exception reporting (all domains)	3.5%	No Data	No Data

	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
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

- An audit was carried out to test whether there was a healthcare inequality in the screening for hypertension affecting patients with anxiety or depression compared to those without these



disorders.

- The result showed that there was a statistically significant association between anxiety disorder and higher rates of screening for hypertension. There was a plan to expand this audit to compare other areas of management of hypertension such as formal diagnosis, treatment and control.

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	P
The learning and development needs of staff were assessed.	N
The practice had a programme of learning and development.	N
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	P
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A
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.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
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: <ul style="list-style-type: none"> <li>• Training records were incomplete and there was no central oversight or monitoring. For example, records did not assure us that all staff had attended infection control training or appropriate safeguarding training.</li> <li>• There were a number of courses which were mandatory for new staff, but there was no structured learning programme following this.</li> <li>• There was no evidence of a formal procedure for managing poor performance, although we were told that staff had been spoken with regarding areas of concern.</li> </ul>	

## 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	Y



where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	
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.	Y
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.	Y

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, 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 (01/04/2018 to 31/03/2019) (QOF)	96.5%	95.7%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.9% (12)	0.6%	0.8%	N/A

## Consent to care and treatment

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

	Y/N/Partial
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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 make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y

## Caring

## Rating: Good

### 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.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>On the day of inspection, we saw reception staff communicating with an agitated patient in a caring and non-judgemental way.</li> </ul>	

### CQC comments cards

Total comments cards received.	25
Number of CQC comments received which were positive about the service.	22
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	3

Source	Feedback
Friends and Family	Staff told us that they had received in excess of 400 comments. On the day of inspection we were told that collating them was work in progress.

### National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
6101.0	421.0	128.0	30.4%	2.10%

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 (01/01/2019 to 31/03/2019)	81.5%	86.3%	88.9%	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 (01/01/2019 to 31/03/2019)	82.2%	85.3%	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 (01/01/2019 to 31/03/2019)	94.3%	94.2%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	82.4%	79.7%	82.9%	No statistical variation

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

### Involvement in decisions about care and treatment

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

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

Source	Feedback
Interviews with patients.	<ul style="list-style-type: none"> <li>Patients we spoke with on the day of inspection told us that they were happy with the care received from the clinical staff.</li> <li>Patients expressed frustration at the difficulty in getting to the surgery as it was not on a bus route and parking was very limited.</li> <li>Patients we spoke to were a combination of people who had either been with the practice in excess of twenty years and those who were relatively new to the surgery.</li> </ul>

### 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 (01/01/2019 to 31/03/2019)	92.3%	92.6%	93.4%	No statistical variation

	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.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified.	<ul style="list-style-type: none"> <li>The practice identified 47 carers which represented 0.78% of the patient list.</li> </ul>
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> <li>There was information in the waiting area on local services for carers.</li> <li>Patients were asked if they were a carer on the new patient registration form.</li> </ul>
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> <li>Patients who were recently bereaved received a letter from the practice giving them details of local support groups and offering them an appointment.</li> </ul>

## 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.	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.	Y

If the practice offered online services:

	Y/N/Partial
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Explanation of any answers and additional evidence:	

# Responsive

Rating: Good

## Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 7.40pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 7.40pm
Friday	8am – 6.30pm
<ul style="list-style-type: none"> <li>Weekend and evening appointments were available at two local surgeries and could be pre-booked by calling the practice.</li> <li>Evening appointments were available from 6.30pm to 8.30pm and weekend appointments were available from 9am to 3pm at both practices.</li> </ul>	

## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
6101.0	421.0	128.0	30.4%	2.10%

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 (01/01/2019 to 31/03/2019)	93.8%	94.0%	94.5%	No statistical variation

## Older people

Population group rating: good

### Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- There was a medicines delivery service for housebound patients by local pharmacies.

## People with long-term conditions

Population group rating: good

### Findings

- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

## Families, children and young people

Population group rating: good

### Findings

- 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: good

### 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.
- The practice was open until 7.40pm on a Monday and Thursday. Pre-bookable appointments were also available to all patients at additional locations within the area from 6.30pm to 8.30pm. Appointments were also available on Saturday and Sunday 9am to 3pm at two local hubs.

## People whose circumstances make them vulnerable

Population group rating: good

### Findings

- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

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

Population group rating: good

### 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.

## 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 absolutely necessary.	Y

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 (01/01/2019 to 31/03/2019)	75.0%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to	75.7%	64.4%	67.4%	No statistical variation



Indicator	Practice	CCG average	England average	England comparison
the overall experience of making an appointment (01/01/2019 to 31/03/2019)				
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	77.6%	61.8%	64.7%	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 (01/01/2019 to 31/03/2019)	77.7%	73.8%	73.6%	No statistical variation

Source	Feedback
NHS Choices	<p>There had been six reviews in the previous twelve months:</p> <p>Three were 5*</p> <p>One was 2*</p> <p>Two were 1*</p> <p>The lower ratings related to medicines management issues and difficulty in making an appointment.</p> <p>The five-star ratings related to clinical care received.</p>

## Listening and learning from concerns and complaints

### Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	5
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
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.	N
Explanation of any answers and additional evidence:	

- Prior to the inspection we saw a list of five complaints which detailed the nature of the complaint and the action taken.
- Although the practice had a system for dealing with complaints, the documentation was disorganised and the effectiveness of the system could be improved to include monitoring for trends and sharing the learning with the staff team.

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient requested a prescription and the clinician issued a prescription but not the amount the patient requested as she had been increasing the amount she had been taking. The clinician was not happy for this to continue. The patient contacted the surgery to complain.	Staff spoke to the patient and explained that the practice had not received any communications from pain management or other services asking them to increase the amount of pain relief. The patient was very unhappy, but staff explained that this was a clinical decision and that the patient would need to make an appointment with the same clinician to discuss the situation.
A patient made a complaint regarding the way she had been spoken to by a receptionist the previous day.	<p>Management spoke to one of the members of staff concerned. She felt that the patient had been very abrupt with them and that the situation had escalated on both sides. The other member of staff concerned was not in that day.</p> <p>Management told the patient they were sorry that they felt that they had been spoken to badly and said staff were never intentionally rude to patients.</p> <p>Management printed off leaflets regarding misunderstanding and how it is possible to give the wrong impression when answering the phone. Management also printed off information regarding verbal &amp; non-verbal communication.</p>

## Well-led

## Rating: Requires Improvement

We rated the practice as requires improvement for providing well-led services. There was a lack of effective systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity.

There was also a lack of effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
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.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>Leaders told us that they were aware of the challenges the practice faced regarding quality of non-clinical systems and processes, however there was a lack of evidence to demonstrate that action had been taken to drive improvement.</li></ul>	

### 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.	Y
There was a realistic strategy to achieve their priorities.	P
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>The practice told us that they had plans for improvement, including working more closely with practices in the locality and in the primary care network. We didn't see any evidence that this had been formalised or monitored.</li></ul>	

## 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.	P
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.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	P
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>We saw no evidence of formal procedures for addressing behaviour inconsistent with the vision and values of the practice, but we were told of an example where a member of staff had been spoken with regarding performance.</li> <li>Training certificates were kept in individual staff files and certificates for equality and diversity training were not present in all files.</li> </ul>	

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

Source	Feedback
Interviews with clinical staff.	<ul style="list-style-type: none"> <li>Staff told us that they felt supported by the lead GP and that they were given the opportunity to share good practice and to seek advice and guidance.</li> </ul>
Interviews with administrative staff.	<ul style="list-style-type: none"> <li>Staff told us that they worked well together as a team and supported each other.</li> <li>One member of staff told us about an issue with management which had not been resolved.</li> </ul>

## Governance arrangements

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

	Y/N/Partial
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There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y

### 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.	Y
There were processes to manage performance.	N
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<p>The practice had completed some one-cycle audits, including, amongst others:</p> <ul style="list-style-type: none"> <li>the number of patients diagnosed with depression and anxiety who had regular blood tests.</li> <li>the number of patients who were prescribed methotrexate who had regular blood tests</li> <li>women of child-bearing age who had been prescribed sodium valproate.</li> </ul>	

### 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.	P
Performance information was used to hold staff and management to account.	N
Our inspection indicated that information was accurate, valid, reliable and timely.	P
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<ul style="list-style-type: none"> <li>There was evidence that clinical data was used to inform and improve performance, but we found that some administrative systems, including those relating to the delivery of safe services were not monitored or reviewed for effectiveness.</li> </ul>	

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Any unusual access was identified and followed up.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had taken over another practice in 2016, but the transfer of all records to system one had not been completed. The practice had an effective system to ensure there was no risk to patients and they were working with the local clinical commissioning group (CCG) and the local medical committee (LMC), to complete the process.</li> </ul>	

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

**The practice involved 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.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> <li>The practice told us that there had been a meeting of the patient participation group, (PPG), the previous week, but there were no minutes available on the day of inspection.</li> <li>There were no members of the PPG available on the day of inspection.</li> </ul>

## 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.	P
Learning was shared effectively and used to make improvements.	P

Explanation of any answers and additional evidence:

- There was a strong focus on continual learning and development within the clinical team, which was shared to improve patient outcomes.
- There was no evidence of learning and development within the practice administration team, apart from mandatory online training courses.

**Examples of continuous learning and improvement**

- One regular GP locum was involved in academic study at two universities and shared the learning within the practice.
- The advanced nurse practitioner completed a masters degree in nursing practice.
- The lead GP was the CCG lead for referral management.
- The lead GP chaired the monthly peer review meeting.

## Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> 1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

## Glossary of terms used in the data.

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