

Care Quality Commission

Inspection Evidence Table

Corkland Road Medical Practice (1-7083174291)

Inspection date: 7 January 2020

Date of data download: 20 December 2019

Overall rating: Good

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

Safe

Rating: Good

Safety systems and processes

The practice had 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. | Y |
| There were policies covering adult and child safeguarding which were accessible to all staff. | Y |
| Policies took account of patients accessing any online services. | Y |
| Policies and procedures were monitored, reviewed and updated. | Y |
| Partners and staff were trained to appropriate levels for their role. | Y |
| There was active and appropriate engagement in local safeguarding processes. | Y |
| The Out of Hours service was informed of relevant safeguarding information. | Y |
| There were systems to identify vulnerable patients on record. | Y |
| 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. | Y |

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

| 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: 9 April 2019 | Y |
| There was a record of equipment calibration. Date of last calibration: 9 April 2019 | Y |
| There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. | Y |
| There was a fire procedure. | Y |
| There was a record of fire extinguisher checks. Date of last check: 1 April 2019 | Y |
| There was a log of fire drills. Date of last drill: 31 December 2019 | Y |
| There was a record of fire alarm checks. Date of last check: 3 January 2020 | Y |
| There was a record of fire training for staff. Date of last training: 8 May 2019 to 9 October 2019 | Y |
| There were fire marshals. | Y |
| A fire risk assessment had been completed. Date of completion: 19 June 2019 | Y |
| Actions from fire risk assessment were identified and completed. | Y |
| <p>A legionella risk assessment had been undertaken on 8 August 2018 which indicated that the building facilities were low risk. We saw evidence of action taken in response to recommendations.</p> <p>An electrical wiring safety inspection had been undertaken on 16 November 2015. We received evidence that action had been taken in response to the recommendations.</p> <p>The annual gas boiler safety inspection was undertaken on 15 October 2019.</p> | |

| Health and safety | Y/N/Partial |
|---|--------------------|
| Premises/security risk assessment had been carried out. Date of last assessment: 3 January 2020 | Y |
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 3 January 2020 | Y |

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. | Y |
| Infection prevention and control audits were carried out. Date of last infection prevention and control audit: October 2019 | Partial |
| The practice had acted on any issues identified in infection prevention and control audits. | Y |
| 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 |
| The most recent infection, prevention and control (IPC) audit for the practice was undertaken in October 2019. This was found to cover the basic IPC audit that was in need of review. We could see from examination of previous IPC audits that the practice had utilised more comprehensive audit tools previously. | |

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. | Y |
| 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 |

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) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA) | 0.87 | 1.00 | 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). (01/10/2018 to 30/09/2019) (NHSBSA) | 10.6% | 8.8% | 8.5% | 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 (01/04/2019 to 30/09/2019) (NHSBSA) | 6.00 | 5.40 | 5.60 | No statistical variation |
| Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA) | 1.77 | 2.23 | 2.08 | No statistical variation |

| 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. | N/A |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. | Y |
| The practice had a process and clear audit trail for the management of information about | Y |

| Medicines management | Y/N/Partial |
|--|-------------|
| changes to a patient's medicines including changes made by other services. | |
| 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. | Y |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | Y |
| For remote or online prescribing there were effective protocols for verifying patient identity. | Y |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates. | 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 |
| There was a process for monitoring patients on high risk medicines with appropriate monitoring and reviews taking place. However, systems could be made more robust to ensure all information is captured. For example, recording the outcome and actions taken in response to patients prescribed Methotrexate. | |

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. | Y |
| Staff understood how to raise concerns and report incidents both internally and externally. | Y |
| There was evidence of learning and dissemination of information. | Y |
| Number of events recorded in last 12 months: | 4 |
| Number of events that required action: | 4 |
| Relevant staff had been involved in discussions regarding significant events and an overview log of each incident had been maintained which included the date, description of the event, learning | |

| |
|----------------------------|
| outcomes and action taken. |
|----------------------------|

Examples of significant events recorded and actions by the practice.

| Event | Specific action taken |
|--------------------------------|--|
| Missed referral | An urgent appointment was organised for the patient and changes to systems and processes were implemented. |
| Information governance breach. | A significant event clinical meeting was held and a full a review of procedures and practice processes was undertaken to mitigate future risk. |

| 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 |
| The practice had a medical alerts policy for clinicians and staff to reference. An electronic system was used to record, disseminate and action a response in relation to safety alerts. | |

Effective

Rating: Good

Effective needs assessment, care and treatment

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

| | Y/N/Partial |
|--|-------------|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice. | 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. | N/A |

| Prescribing | Practice performance | CCG average | England average | England comparison |
|---|----------------------|-------------|-----------------|--------------------------|
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small> | 0.80 | 1.08 | 0.74 | No statistical variation |

Older people

Population group rating: Good

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.
- The practice carried out structured annual medication reviews for older patients.
- 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: **Good**

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.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- 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.
- 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.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

| 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) (QOF) | 70.3% | 77.7% | 79.3% | No statistical variation |
| Exception rate (number of exceptions). | 3.1% (12) | 14.0% | 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) (QOF) | 79.2% | 75.7% | 78.1% | No statistical variation |
| Exception rate (number of exceptions). | 2.8% (11) | 11.5% | 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> | 72.2% | 80.3% | 81.3% | Tending towards variation (negative) |
| Exception rate (number of exceptions). | 4.1% (16) | 11.8% | 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> | 69.7% | 74.8% | 75.9% | No statistical variation |
| Exception rate (number of exceptions). | 1.4% (6) | 8.2% | 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> | 84.8% | 87.2% | 89.6% | No statistical variation |
| Exception rate (number of exceptions). | 4.8% (4) | 11.3% | 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) (QOF) | 79.4% | 80.4% | 83.0% | No statistical variation |
| Exception rate (number of exceptions). | 2.3% (15) | 5.4% | 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) (QOF) | 82.7% | 91.2% | 91.1% | No statistical variation |
| Exception rate (number of exceptions). | 3.7% (2) | 6.8% | 5.9% | N/A |

Families, children and young people

Population group rating: Good

Findings

- The practice has met the minimum 90% target for all four childhood immunisation uptake indicators.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- 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) | 85 | 92 | 92.4% | 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) | 104 | 113 | 92.0% | Met 90% minimum |
| The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England) | 105 | 113 | 92.9% | Met 90% minimum |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England) | 104 | 113 | 92.0% | Met 90% minimum |

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

| 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 | 71.4% | N/A | 80% | Below 80% target |

| | | | | |
|--|-------|-------|-------|--------------------------|
| period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (31/03/2019 to 30/06/2019) (Public Health England) | | | | |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE) | 64.3% | 58.3% | 71.6% | N/A |
| Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE) | 46.5% | 46.2% | 58.0% | 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. (01/04/2018 to 31/03/2019) (PHE) | 84.2% | 69.2% | 68.1% | N/A |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE) | 40.0% | 53.6% | 53.8% | No statistical variation |

Any additional evidence or comments

The practice told us that they were aware of the low cervical cancer screening rates. They had many transient patients and also a significant number of patients who are non-English speaking. The practice also advised there may have been a coding issue where smears may have been recorded incorrectly. The practice were looking at incentives to encourage attendance and increased uptake.

People whose circumstances make them vulnerable

Population group rating: Good

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.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

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

Population group rating: Good

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.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- 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 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> | 68.5% | 84.8% | 89.4% | Variation (negative) |
| Exception rate (number of exceptions). | 5.2% (4) | 11.1% | 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> | 66.2% | 88.7% | 90.2% | Variation (negative) |
| Exception rate (number of exceptions). | 3.9% (3) | 9.1% | 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> | 78.6% | 85.0% | 83.6% | No statistical variation |
| Exception rate (number of exceptions). | 0.0% (0) | 4.9% | 6.7% | N/A |

Any additional evidence or comments

We discussed with the practice the care plan agreement between mental health patients and the practice. We viewed a sample of patient records and found care plans were in place as necessary. The practice

also told us that previously there was a coding issue identified and addressed, which may also be reflected in the low figure.

Monitoring care and treatment

The practice used the quality and outcomes framework to monitor patient outcomes and undertook clinical audits to support quality improvement of care and treatment.

| Indicator | Practice | CCG average | England average |
|--|----------|-------------|-----------------|
| Overall QOF score (out of maximum 559) | 504.7 | 533.0 | 539.2 |
| Overall QOF score (as a percentage of maximum) | 90.3% | 95.4% | 96.7% |
| Overall QOF exception reporting (all domains) | 3.1% | 7.4% | 5.9% |

| | 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 |

Any additional evidence or comments

The practice had signed up to the Manchester Standards – a set of objectives for the practice to achieve to deliver safe and effective services.

Prior to our inspection we asked the provider to send us evidence that the quality of treatment and services had been monitored, actions taken and outcomes as a result of this. The practice manager sent us a copy of a two-cycle minor surgery clinical audit. The first cycle was undertaken from July to September 2017 and the second cycle during 2018 to 2019.

We also received a two-cycle audit that had been undertaken with support from the medicines optimisation team during 2017 to 2019. This audit was undertaken in response to a patient safety alert for patients prescribed a medicine called Sodium Valproate. Additionally, we were provided with a copy of a re-audit for gynaecology referrals that was dated January 2019.

Practice leaders told us that audits were identified opportunistically. We saw further evidence of other recently commenced clinical audits during the inspection. For example, a first cycle audit in relation to end of life care and an audit of the prescribing of NSAIDS, Lithium and Valproate.

Effective staffing

The practice was 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. | Y |
| The learning and development needs of staff were assessed. | Y |
| The practice had a programme of learning and development. | Y |
| Staff had protected time for learning and development. | Y |
| There was an induction programme for new staff. | Y |
| Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015. | Y |
| 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. | Y |
| The practice had developed a training policy and a summary of mandatory and recommended training for clinicians and non-medical staff. A range of records for induction and key training areas had been developed and systems had been established by the practice manager to track progress and monitor the ongoing training needs of staff. | |

Coordinating care and treatment

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

| Indicator | Y/N/Partial |
|---|-------------|
| The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF) | Y |
| 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 | Y |

| | |
|---|-----|
| services. | |
| For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services. | N/A |
| Practice leaders coordinated monthly meetings to engage with key multi-disciplinary team members and ensure the provision of coordinated and integrated pathways of care. | |

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) <small>(QOF)</small> | 90.7% | 94.2% | 95.0% | Tending towards variation (negative) |
| Exception rate (number of exceptions). | 1.1% (14) | 1.1% | 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 |
|--|-------------|
| 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 |
| Staff were aware of issues around consent and were able to describe the process by which they sought consent from patients. | |

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 |

| CQC comments cards | |
|--|----|
| Total comments cards received. | 37 |
| Number of CQC comments received which were positive about the service. | 33 |
| Number of comments cards received which were mixed about the service. | 4 |
| Number of CQC comments received which were negative about the service. | 0 |

| Source | Feedback |
|------------------------------------|--|
| Comments cards | The majority of comment cards received (33) provided positive feedback about the practice and the standard of care and treatment received from clinicians and staff. The four mixed feedback comment cards highlighted feedback relating to appointment booking times. |
| Friends and Family | We looked at the results for the practice's friends and family test on 06/01/2020. This showed that out of seven responses all patients (100%) would be highly likely or likely to recommend the practice. |
| NHS Choices | We looked at the feedback on NHS choices on 06/01/2020. Records indicated that there had been one review of the practice since the registration of the current provider in July 2019. This was a one-star rating from a patient who raised concerns regarding the waiting time for an appointment. |
| Patient Participation Group (PPG). | At the time of our inspection the practice did not have an active PPG. The practice maintained a PPG email distribution list and produced quarterly bulletins to update patients on key information. The practice manager told us that the practice planned to establish an active PPG and we saw evidence of these discussions in practice meeting minutes. |

National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 7208.0 | 466.0 | 107.0 | 23.0% | 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 (01/01/2019 to 31/03/2019) | 80.1% | 88.5% | 88.9% | Tending towards variation (negative) |
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019) | 73.7% | 86.6% | 87.4% | Variation (negative) |
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019) | 85.9% | 95.3% | 95.5% | Variation (negative) |
| 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) | 71.4% | 82.2% | 82.9% | No statistical variation |

Any additional evidence or comments

The practice was aware of the lower than average scores in some areas of the GP Patient Survey. The practice felt the areas of lower than average survey results were reflective of the low uptake of patient responses (466 surveys sent out, 107 surveys sent back and a 23% completion rate).

The practice continued to encourage patients to provide feedback on their experience of using the practice via a suggestion box, face to face contact, "how are we doing forms"; monitoring feedback from the friends and family feedback tool, cards and complaints. Action plans were produced in response to feedback received. For example, some patients had raised concerns regarding difficulty in getting through to the practice via the telephone. In response the practice had installed a new telephone line in August 2019 with enhanced technology to offer more lines and improves access.

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

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 |
| Information for patients on family health, long term conditions and diseases and minor illness was available on the practice website and in the practice's waiting room. Staff told us they would provide information and advice and signpost patients to support groups and advocacy services subject to individual need. | |

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) | 83.9% | 93.1% | 93.4% | Tending towards 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. | Y |
| Information about support groups was available on the practice website. | Y |

| Carers | Narrative |
|---|---|
| Percentage and number of carers identified. | The practice had identified approximately 449 patients as carers, which represented 6% of the practice list size. |
| How the practice supported carers (including young carers). | The practice maintained a register of carers. Carers were identified via the registration process and also opportunistically. Clinicians and staff signposted carers to appropriate support services when required. Free flu vaccinations and health checks were also offered to carers. Staff had completed carer awareness training to help them understand the needs of carers and how to provide responsive care and support. |
| How the practice supported recently bereaved patients. | Practice staff issued a letter to recently bereaved patients to offer their support and condolences. GPs also offered ongoing care and support and patients were signposted to relevant support services such as the Bereavement Care Team. |

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 |

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 | 8 am to 8.30 pm |
| Tuesday | 7.30 am to 6.30 pm |
| Wednesday | 7.30 am to 6.30 pm |
| Thursday | 7.30 am to 6.30 pm |
| Friday | 7.30 am to 6.30 pm |
| Appointments available: | |
| Monday | 8.40 am to 8.30 pm |
| Tuesday | 7.30 am to 5.30 pm |
| Wednesday | 7.30 am to 5.30 pm |
| Thursday | 7.30 am to 5.30 pm |
| Friday | 7.30 am to 5.30 pm |
| Extended hours, out of hours and weekend appointments | The practice was part of a federation of GP practices who provide extended hours cover in the area from 8am to 8pm, seven days a week. Registered patients could access extended hours appointments via the Manchester Extended Access Service (MEAS). The extended access service was delivered from designated 'hubs' across Manchester. A number of appointments were bookable via the practice and operating times of the service varied between each location. Appointments were available at all sites between 6.00pm and 8.00pm on weekdays and on Saturday and Sunday mornings. Out of hours cover was provided by Go to Doc. |

National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 7208.0 | 466.0 | 107.0 | 23.0% | 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 (01/01/2019 to 31/03/2019) | 80.5% | 93.8% | 94.5% | Significant Variation (negative) |

Any additional evidence or comments

The practice were aware of the lower than average scores in some areas of the GP Patient Survey. The practice felt the areas of lower than average survey results were reflective of the low uptake of patient responses (466 surveys sent out, 107 surveys sent back and a 23% completion rate).

The practice continued to encourage patients to provide feedback on their experience of using the practice via a suggestion box, face to face contact, "how are we doing forms"; monitoring feedback from the friends and family feedback tool, cards and complaints. Action plans were produced in response to feedback received.

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.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- 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 and community matrons 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

- Additional nurse appointments were available from 7.30 am from Tuesday to Friday for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. 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: 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 8.30 pm on a Monday. Pre-bookable appointments were also available to all patients at additional locations within the area in evenings, as the practice was a member of a GP federation. Appointments were also available on a Saturday and Sunday morning.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people those with a learning disability.
- 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.

| | 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 |

National GP Survey results

| Indicator | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------------------------|
| The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2019 to 31/03/2019) | 73.6% | N/A | 68.3% | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019) | 47.3% | 65.7% | 67.4% | Tending towards variation (negative) |
| The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019) | 49.9% | 66.0% | 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) | 46.7% | 70.1% | 73.6% | Variation (negative) |

Any additional evidence or comments

The practice continued to encourage patients to provide feedback on their experience of using the practice via a suggestion box, face to face contact, "how are we doing forms"; monitoring feedback from the friends and family feedback tool, cards and complaints. Action plans were produced in response to feedback received.

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. | 18 |
| 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. | Y |
| The practice had developed a complaints procedure and an information leaflet on how to raise a complaint was available for patients to reference. Systems had also been established to enable practice leaders to maintain an overview of complaints and to analyse key information regarding the type of complaint, specific details and the outcome of any investigation. | |

Examples of learning from complaints.

| Complaint | Specific action taken |
|---|---|
| A patient booked an appointment which had not been recorded on the system. | A standard response was sent to the patient which acknowledged receipt of the complaint and included information on how to raise the concern with the Parliamentary and Health Service Ombudsman. The practice manager also contacted the patient by phone to explain the reason for the error and to offer an apology on behalf of the practice. Complaints were also discussed with staff via daily meetings to share information and learning. |
| A patient raised concerns regarding their experience of a routine consultation with a GP. | A standard response was sent to the patient which acknowledged receipt of the complaint and included information on how to raise the concern with the Parliamentary and Health Service Ombudsman. The clinician concerned also wrote a letter to the patient to clarify their understanding of the consultation and to offer an apology. |

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels

| | Y/N/Partial |
|--|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | Y |
| They had identified the actions necessary to address these challenges. | Y |
| Staff reported that leaders were visible and approachable. | Y |
| There was a leadership development programme, including a succession plan. | Y |
| Staff spoken with were complimentary about the leadership at the practice and confirmed that management were approachable, supportive and inclusive. There was strong collaboration and support across the entire team and a common focus on continuous improvement. | |

Vision and strategy

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

| | Y/N/Partial |
|--|-------------|
| The practice had a clear vision and set of values that prioritised quality and sustainability. | Y |
| There was a realistic strategy to achieve their priorities. | Y |
| 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. | Y |
| The practice had developed a vision statement which included aims and objectives. A business plan had also been developed which covered succession planning and outlined areas for development such as skill mix, premises development and financial management. | |
| The practice was in the early stages of developing a patient participation group. | |

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. | 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. | 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. | Y |
| Policies and procedures had been developed for staff to reference in regard to whistleblowing and to ensure compliance with the duty of candour. Staff we spoke with told us that there was an open and transparent culture within the practice and that any concerns could be raised with practice leaders. | |

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

| Source | Feedback |
|------------------|--|
| Staff interviews | Staff told us that there was a good team ethic at the practice and that they were keen to provide the highest levels of service to patients. |

Governance arrangements

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

| | Y/N/Partial |
|---|-------------|
| There were governance structures and systems which were regularly reviewed. | Y |
| Staff were clear about their roles and responsibilities. | Y |
| There were appropriate governance arrangements with third parties. | Y |
| The practice had developed a wide range of policies, procedures and protocols that were available to staff and had been kept under review. | |
| Staff were clear regarding their roles and responsibilities and who to contact should they need to raise an issue or receive help and support. Designated leads had been appointed for key areas such as safeguarding, prescribing, infection control, health and safety and patient support etc. | |
| Communication was effective and facilitated via both informal and structured minuted meetings and | |

emails. Practice leaders maintained oversight of significant events, complaints, safety alerts, clinical cases and policies and procedures was in place.

Managing risks, issues and performance

There were 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. | Y |
| There was a systematic programme of clinical and internal audit. | 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 |
| <p>A staff performance review policy had been developed to provide practice leaders and staff with information on performance management processes. A comprehensive business continuity plan was also in place which offered guidance for staff on the action to take in the event of an emergency situation. We noted that the practice manager had sought training opportunities for staff in preparation for major incidents.</p> <p>We saw evidence of clinical and internal audits however a rolling programme of clinical audits had not been established. Practice leaders told us that audits were identified opportunistically.</p> | |

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

| | Y/N/Partial |
|--|-------------|
| Staff used data to adjust and improve performance. | Y |
| Performance information was used to hold staff and management to account. | Y |
| Our inspection indicated that information was accurate, valid, reliable and timely. | Y |
| There were effective arrangements for identifying, managing and mitigating risks. | Y |
| Staff whose responsibilities included making statutory notifications understood what this entails. | Y |

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. | Y |
| The practice had an active Patient Participation Group. | No |
| 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 |
| At the time of our inspection the practice did not have an active PPG. The practice maintained a PPG email distribution list and produced quarterly bulletins to update patients on key information. The practice manager told us that the practice planned to establish an active PPG and we saw evidence of these discussions in practice meeting minutes | |

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

| | Y/N/Partial |
|--|-------------|
| There was a strong focus on continuous learning and improvement. | Y |
| Learning was shared effectively and used to make improvements. | Y |
| Practice leaders demonstrated an ethos and commitment towards continuous improvement. The practice had developed a training policy and a summary of mandatory and recommended training for clinicians and non-medical staff. Systems had been established by the practice manager to track progress, share learning and monitor the ongoing training needs of staff. | |

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) | ≤ -3 |
| Variation (positive) | > -3 and ≤ -2 |
| Tending towards variation (positive) | > -2 and ≤ -1.5 |
| No statistical variation | < 1.5 and > -1.5 |
| Tending towards variation (negative) | ≥ 1.5 and < 2 |
| Variation (negative) | ≥ 2 and < 3 |
| Significant variation (negative) | ≥ 3 |

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

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

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

Glossary of terms used in the data.

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