

Care Quality Commission

Inspection Evidence Table

St Werburgh Medical Practice (1-4551112454)

Inspection date: 19 June 2020

Date of data download: 17 June 2020

At our previous inspection on 5 and 6 November 2020 we rated the practice as inadequate overall and the rating remains unchanged. Following our inspection on 5 and 6 November 2019 warning notices were issued in respect of Regulation 12 (1) Safe care and treatment), Regulation 17 (1) Good governance and Regulation 18 (1) Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe

Safety systems and processes

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
There was active and appropriate engagement in local safeguarding processes.	No
Explanation of any answers and additional evidence: We reviewed a sample of correspondence received by the practice, and individual care records. We saw that requests for six GP safeguarding reports had been received and the blank forms saved onto individual care records. We saw no evidence that the GP reports had been completed. The individual care records did not contain completed reports.	

Recruitment systems	Y/N/Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	No
<p>Explanation of any answers and additional evidence:</p> <p>The practice had identified through their infection control audit that they were not monitoring that staff vaccination was in line with PHE guidance. At the time of our inspection the provider was in the process of checking staff immunity status although the provider told us that they had been unable to access blood tests for immunity for some staff during the COVID 19 response.</p>	

Safety systems and records	Y/N/Partial
<p>There was a record of portable appliance testing or visual inspection by a competent person.</p> <p>Date of last inspection/test: 06/03/2020</p>	Yes
<p>There was a record of equipment calibration.</p> <p>Date of last calibration: 28/01/2020</p>	Yes
<p>There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.</p>	Partial
<p>There was a record of fire extinguisher checks.</p> <p>Date of last check: 19/05/2020</p>	Yes
<p>There was a log of fire drills.</p> <p>Date of last drill: 29/05/2020</p>	Yes
<p>There was a record of fire alarm checks.</p> <p>Date of last check: 18/06/2020</p>	Yes
<p>A fire risk assessment had been completed.</p> <p>Date of completion: 31/010/2019</p>	Yes
<p>Actions from fire risk assessment were identified and completed.</p>	No
<p>Explanation of any answers and additional evidence:</p> <p>Basic Control of Substances Hazardous to Health (COSHH) risk assessments were available on the practice shared system. Leaders in the service told us that these were downloaded and tailored to the practice. It was not clear how staff would easily access the specific risk assessments for this surgery. We asked the leaders in the service for the COSHH risk assessments specific to this surgery, in particular for the COSHH risk assessment for the ant powder that had been used in the staff kitchen area in April 2020. The leaders told us that they did not have one and that it was the responsibility of the cleaning company who had put the ant powder down. Leaders in the service contacted the cleaning company, and were informed the cleaning company did not have a COSHH risk assessment for the ant powder.</p> <p>Actions had been identified in the fire risk assessment, but they had not all been completed. For example, the fire risk assessment stated that the provider should obtain evidence such as a copy of the Electrical Installation Condition Report to demonstrate that fixed hard wired electric circuits were in a satisfactory condition. This action was due to be completed by 31/12/2019. Management staff showed us what they believed to be the Electrical Installation Condition Report however this document was a record of</p>	

portable appliance testing dated 09/01/2016. Staff were unable to show us any evidence that this action had been completed.

The provider showed us an updated copy of the risk assessment action plan which was generated on 26/05/2020. This showed four further control measures that were required were overdue, three were due to be completed by 14/11/2019 and one by 31/12/2019.

In the fire safety logbook the fire door checklist showed the door to room three had been marked as unsatisfactory since 07/04/2020 however the action log was only updated on 05/06/2020 regarding this door. The action log showed that an email had been sent to the practice manager but there was no target date for completion and there was no evidence that any action had been taken to resolve this.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 15/05/2020	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Partial
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: The infection prevention and control audit identified seven actions, three of which had been completed, three were in progress and there was no evidence that the other had been started.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	No
When there were changes to services or staff the practice assessed and monitored the impact on safety.	No
Explanation of any answers and additional evidence: We found that the provider did not have sufficient clinical cover to meet the needs of patients. Staff we spoke with told us that they thought there was insufficient clinical and administrative cover. There was less clinical and administrative cover than at our previous inspection of 5 and 6 November 2019. We asked the provider to explain how they assessed the number of appointments they offered. The provider was unable to provide evidence of how they had determined how many appointments to offer. There was no evidence of any minuted meetings where demand and capacity were discussed and there was no analysis of the patient demand/need. The provider told us at our previous inspection of 5 and 6 November 2019 that they offered 100 appointments per 1,000 patients per week. At this inspection the provider told us that they now only offered 50 appointments per 1,000 patients per week. We asked the	

provider to explain how they had decided that 50 appointments per 1,000 patients per week was appropriate to meet the needs of patients and they told us they had not based their decision on any analysis of patient demand or need.

We noted that a significant events record had been raised due to the Gillingham branch site being closed for an afternoon in March 2020 due to staff shortages. The provider's action was to try and ensure they had enough staff for both sites.

Information to deliver safe care and treatment

Staff did not have 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.	No
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Partial
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	No
There was a documented approach to the management of test results and this was managed in a timely manner.	No
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	No
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.	Partial

Explanation of any answers and additional evidence:
 We reviewed 22 individual care records and found that not all were appropriately maintained to ensure safe patient care. For example, we found medicines reviews were not appropriately coded and one individual care record did not contain sufficient detail it only contained clinical codes for recent consultations.

We found that when correspondence or test results required action this was not always done or done in a timely manner. For example, we found one patient's individual care record had blood test results from June 2019 which were annotated to contact patient but there was nothing recorded to show that the patient had been contacted or any further action had been taken. We also found a backlog of 26 letters, with the oldest being received by the practice in February 2020. We reviewed six of these letters and found five had requests for referrals which had not been done and one referral which was delayed by five weeks.

Appropriate and safe use of medicines

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

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	No
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.	No
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.	No
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>There was a documented repeat prescribing policy. However, when we reviewed individual care records, we found that this was not always adhered to.</p> <p>We reviewed samples of individual care records for patients on various disease registers and found;</p> <p>Four records for patients who had a current diagnosis of asthma and found one patient whose repeat medicines had not been reviewed appropriately.</p> <p>Five records for patients who had been diagnosed with chronic obstructive pulmonary disease and found one patient whose repeat medicines had not been reviewed appropriately.</p> <p>Five records for patients who had a current diagnosis of diabetes and found two of these patients whose repeat medicines had not been reviewed appropriately.</p> <p>Five records of patients who were receiving end of life care and found three of these patients whose repeat medicines had not been reviewed appropriately, particularly when adding or changing medicines.</p> <p>Four records of patients who had a current diagnosis of a mental health disorder. One patient was not currently prescribed medicines and of the other three we found two patients whose repeat medicines had not been reviewed appropriately, particularly when adding or changing medicines. The last recorded medicines review for one of these patients was 2016.</p> <p>Three records of patients who had a current diagnosis of dementia. We found none of these patients repeat medicines had been reviewed appropriately, particularly when adding or changing medicines. The last recorded medicines review for one of these patients was 2016.</p> <p>We saw two examples where inappropriate long term repeat prescribing of medicines likely to cause dependency had been identified and the respective patient's medicines had been stopped. A letter had been sent to each of these patients to advise them the medicine had been stopped. There was no appropriate follow up recorded in either of the patient's individual care records. We saw a further example of long term repeat prescribing of inappropriate long term repeat prescribing of a medicine likely to cause dependency. In this record we saw no effort had been made to reduce the dose despite an advisory to a prescribing alternative.</p>	

Medicines management	Y/N/Partial
<p>We reviewed 28 records of patients who, at the time of our inspection, were prescribed high risk medicines. We found that one patient did not have appropriate monitoring recorded and 26 patients whose medicines had not been reviewed in the last 12 months. We found that of these 26 patients the last recorded medicine review for one patient was 2014, one patient was 2015, one patient was 2016, six patients were 2017, 15 patients were 2018 and three patients were early 2019.</p> <p>We also found that one patient who was prescribed warfarin (a medicine which is an anticoagulant, used to prevent blood clots) whose blood test results were up to date had not requested their medicine since April 2020. There was nothing in the patient's medical record that indicated the clinical team had contacted the patient or taken any other action to determine why they were still having blood tests but not requesting their medicines.</p> <p>We reviewed fridge temperature monitoring logs for St Werburgh from 21/04/2020 to date and found that where the temperature was recorded out of range an appropriate reason was recorded. We also reviewed two significant events where the cold chain had been breached and found that appropriate action had been taken.</p> <p>However, we did find there were gaps in the daily recording, for example no temperatures were recorded between 6 May 2020 and 12 May 2020, this period included two days when the practice was open. We noted that on most days only one temperature was recorded but on three dates two temperature readings were recorded with no explanation.</p>	

Track record on safety and lessons learned and improvements made

The practice did not always learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
There was a system for recording and acting on significant events.	Partial
There was evidence of learning and dissemination of information.	Partial
Number of events recorded since last inspection:	24
Number of events that required action:	22
Explanation of any answers and additional evidence:	
<p>Since February 2020 the practice has implemented a spreadsheet to record and monitor significant events. This was in addition to the DATIX system, that the incident management policy, stated must be used to record significant events. There was some evidence of learning and the dissemination of information through this spreadsheet and the clinical meeting minutes we reviewed. However, there was no review of significant events to ensure actions had been taken. For example, a significant event was recorded in April 2020 where the practice determined that a patient was significantly overdue a monitoring blood test which was required to safely prescribe their medicine. The action taken was to take this medicine off repeat. However, when we reviewed the patient record, we found no record that the blood test had been completed even though the patient had been prescribed this medicine again on 12 June 2020.</p>	

We found not all significant events were shared within an appropriate timescale. For example, an event recorded in March 2020 was not discussed in a clinical meeting until May 2020.

We also found that learning was not always considered more widely. For example, a significant event was recorded in February 2020 where a monitoring blood test had not been completed within the appropriate timescale, but the medicine had still been prescribed. This was discussed at a clinical meeting in February and the action recorded as taken, by the practice, was to send an email reminder to all clinicians to check blood test results. There was no system in place to ensure clinicians had read and acted upon the email. We found there had been a further significant event regarding the same medicine being prescribed without an up to date blood test result was recorded in March 2020.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: We saw examples of actions taken on recent alerts. For example, discussions regarding three recent alerts were recorded in the clinical meeting minutes dated 16 June 2020.	

Effective

Effective needs assessment, care and treatment

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

	Y/N/Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	No
Patients' treatment was regularly reviewed and updated.	No
There were appropriate referral pathways to make sure that patients' needs were addressed.	Partial
Explanation of any answers and additional evidence: When we reviewed patients' individual care records, we found that they had not all had their needs appropriately or fully assessed. For example; two patients who attended for a dementia review did not have an adequate assessment recorded in their records. There were appropriate referral pathways to ensure that patients needs were addressed however we found these were not always used. For example; a patient who was requesting a referral to hospital for a follow up was told to contact the hospital directly, the hospital told them that the GP needed to complete the appropriate referral. We also found that some patients had not been referred to another practitioner when it was indicated they should have been. For example, a patient with deteriorating blood test results which suggested poorly controlled diabetes was not referred to a prescriber who could make the appropriate medicine adjustment. We also reviewed five individual care records for patients who were receiving end of life care and found that two patients had not been referred to the palliative care team.	

Older people

Findings

- The practice did not always follow up on older patients discharged from hospital. It did not ensure that their care plans and prescriptions were updated to reflect any extra or changed needs. For example, an elderly patient was discharged from Accident and Emergency, the discharge letter was received by the GP practice in February 2020 requesting the GP arrange a follow up as there was a suspected recurrence of a health issue. At the time of our inspection there was no evidence that the follow up had been arranged and there was no reference to this in the patient's individual care records.
- The practice did not always carry out structured annual medication reviews for older patients and there was no system in place to ensure these reviews were carried out.

People with long-term conditions

Findings

- Patients with long-term conditions were not always offered a structured annual review to check their health needs, , including any required medicines, were being met.
- We reviewed five individual care records of patients diagnosed with chronic obstructive pulmonary disease (COPD) and found that care provided to two of these patients was not based on current best practice guidance. We reviewed four individual care records of patients diagnosed with asthma and found they were all managed appropriately. However, we found one patient whose repeat medicines had not been reviewed appropriately.
- We reviewed five individual care records of patients diagnosed with diabetes and found that care provided to two of these patients was not based on current best practice guidance.
- Patients with asthma were offered an asthma management plan. When we reviewed the significant events recorded by the practice since our last inspection, we noted that the pharmacist had identified one patient who had been prescribed inhalers that were not in line with current best practice guidance. The practice had since taken some steps to rectify this.
- We reviewed two individual care records of patients diagnosed with hypertension and found that they were both managed appropriately.

People whose circumstances make them vulnerable

Findings

- End of life care was not always delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- We reviewed five individual care records of patients who were on the practice's end of life register. We found that only two patients had anticipatory care plans and discussions regarding resuscitation recorded. We also found that there was no evidence that two patients had received appropriate follow up or referral to the palliative care team.
- We found that the provider had identified 15 patients as receiving end of life care. This number was substantially less than we would expect in a practice of this size.
- We found that the end of life register was not up to date as we found that three patients had been removed from the register with no reason recorded.
- The practice had an end of life list on a board in the staff area of the practice and we found the board was not up to date as one patient who was listed on the board had died in 2018. We also found that the end of life register did not match the list of patients on the board.

People experiencing poor mental health (including people with dementia)

Findings

- The practice did not always assess and monitor 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. We reviewed the individual care records of patients with mental illness and found two patients had not been appropriately assessed or monitored. We also found that one patient had not been referred to another clinician where appropriate.
- There was an ineffective system for following up patients who failed to attend for administration of long-term medication. We found that the provider did not take appropriate action when patients failed to comply with appropriate monitoring. For example, one patient had not responded to seven letters from the practice and one had not responded to five letters but the action taken by the practice, in respect of both patients, was to send another letter. The practice did not take any other action to try to engage with these patients.
- When patients were assessed to be at risk of suicide or self-harm the practice did not put arrangements in place to help them to remain safe. For example, the practice received a letter from the Crisis team in February 2020 regarding a patient who was at serious risk of self harm which requested a referral to psychological therapies service. At the time of our inspection this referral had not been done.
- We reviewed the individual care records for three patients who had been diagnosed with dementia. We found only one of these patients had an adequate assessment of the patient's condition evidenced in their record. One individual care record showed that the patient should have been contacted in June 2019 regarding their blood tests results, however at the time of our inspection the patient had not been contacted. We found that none of the patients repeat prescriptions had been reviewed when their medicines were altered, and one patient last had a medicine review recorded in 2016.

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 access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
Explanation of any answers and additional evidence:	
At our last inspection of 5 and 6 November 2019 we found that staff had not had regular appraisals. At this inspection we saw evidence that staff had received appraisals.	

Coordinating care and treatment

Staff did not work together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	No
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed individual care records of five patients on the palliative care register and found two patients had not been referred appropriately to the palliative care team.</p> <p>We reviewed a sample of 26 individual care records and found five had not been referred to other organisations where it was clinically appropriate to do so.</p> <p>We reviewed a sample of six letters received by the practice and found five contained requests for referrals or assessments that had not been done by the practice at the time of our inspection. The referral requested in one letter had been completed but there was a five week delay between when the practice received the request and the referral being completed by the practice.</p>	

Responsive

Responding to and meeting people's needs

Practice Opening Times	
Day	Time
Opening times: St Werburgh Medical Practice	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Opening times: The Healthy Living Centre Gillingham branch	
Monday	8.30am to 12.30pm and 3pm to 6pm
Tuesday	8.30am to 12.30pm and 3pm to 6pm
Wednesday	8.30am to 12.30pm and 3pm to 6pm
Thursday	8.30am to 12.30pm
Friday	8.30am to 12.30pm and 3pm to 6pm
Opening times: Stoke Village Hall branch	
Monday	8.30am to 12.30pm
Tuesday	closed
Wednesday	8.30am to 12.30pm
Thursday	closed
Friday	8.30am to 12.30pm
Explanation of any answers and additional evidence:	
<p>On the day of our inspection we asked the provider what their current opening hours were. The provider told us that due to the COVID 19 pandemic all patients were being triaged by St Werburgh Medical Practice, the Stoke Village Hall branch was closed and the Gillingham branch was operating reduced hours.</p> <p>We asked the provider how they had informed patients that the two branch surgeries were either closed or had reduced opening times. They told us that there were notices displayed at the branch surgeries and it was on the practice website. We looked at the practice website on the day of inspection and found that it was displaying the normal opening hours and there was nothing else on the website to indicate the branches were both closed.</p>	

Listening and learning from concerns and complaints

Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received since our last inspection (5 & 6 November 2019).	10
Number of complaints we examined.	7
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0
<p>Explanation of any answers and additional evidence:</p> <p>Only three of the seven complaints we reviewed were handled within the timescales laid out in the practice's Complaints, Comments and Compliments Management Policy or by the timescales that were provided to the complainants.</p> <p>We found that the complaints records in the provider's DATIX system were not always complete. For example; three complaints received between December 2019 and April 2020 did not have completion dates or final response letters in the system.</p>	

	Y/N/Partial
Information about how to complain was readily available.	Partial
There was evidence that complaints were used to drive continuous improvement.	No
<p>Explanation of any answers and additional evidence:</p> <p>There was an information leaflet available on the reception desk which gave patients information about how to complain. However, we did not find any information about how to complain on the practice website.</p> <p>We also found that only two complainants had been provided with signposting information of how to escalate their complaint if they were unhappy with the providers response.</p> <p>We found that the practice had not completed any analysis of complaints to identify trends or taken sufficient action to drive improvement. For example; the practice received a complaint in early March 2020 regarding delays in receiving a prescription and the practice investigation showed that this occurred as the GP was not set up to send prescriptions electronically. At the beginning of April 2020, the practice received a further complaint regarding delays in receiving a prescription and the practice investigation again showed that the GP had not been able to use electronic prescribing.</p>	

Well-led

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Partial
Explanation of any answers and additional evidence: Since our last inspection on 5 and 6 November 2019 the practice had employed a new practice manager and a clinical lead. Overall leadership was the responsibility of two partners (one GP and one non-clinical partner), neither of whom worked on site. The partners also had responsibility for a number of other healthcare locations, community services and specialty services. Senior leaders on site that we spoke with told us that they felt well supported by the partners. The provider did not demonstrate that they had identified and taken action to become compliant with the warning notices that we issued following our last inspection on 5 and 6 November 2019.	

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
There was a realistic strategy to achieve their priorities.	No
Progress against delivery of the strategy was monitored.	No
Explanation of any answers and additional evidence: The provider told us that they had a clear vision but when we asked they told us they did not have a documented strategy to improve the standard of care at the practice. When we asked the provider how they planned and monitored their service, such as the number of appointments they offered the partners told us that they did not have a documented analysis or plan.	

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>When we spoke to the partners it was not clear that they understood their responsibilities as the provider of the service.</p> <p>During our inspection it was also unclear where responsibility sat between leaders in the service on site and managers who worked for the providers larger organisation.</p>	

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.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
When considering service developments or changes, the impact on quality and sustainability was assessed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>We found that there was not appropriate oversight of systems to ensure they were working as the provider intended. For example; incoming correspondence was not always acted upon in a timely manner. The managers in the service and the partners were not aware there was a backlog of incoming correspondence in the clinical system dating back to February 2020 which had not been acted on appropriately.</p> <p>When we spoke with the partners, they told us they had not carried out any analysis of their population or the needs of their patients when they reduced the amount of appointments they offered or the reduction of advanced nurse practitioner sessions.</p> <p>The provider told us that they were planning to move all their estates Health and Safety records, policies and other documents to a new online system, however this was not in use at the time of our inspection.</p>	

Appropriate and accurate information

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

	Y/N/Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
Explanation of any answers and additional evidence:	
<p>We found that information was not always up to date. For example, one of the patients on the palliative care register had died in 2018 and we found that individual care records were not always clear, accurate and contemporaneous. We also found that requests for GP safeguarding reports were not always completed within individual care records.</p> <p>The provider and leaders in the service were not managing and mitigating risks in line with risk assessments that had been carried out. For example, the fire risk assessment had outstanding actions which should have been completed by November 2019 and December 2019. The partners and managers in the service were not aware of this until we brought it to their attention during the inspection.</p> <p>The provider and leaders in the service were not monitoring third party contractors who carried out work on the premises appropriately. For example, the managers in the service and the partners were not aware that the company employed to monitor water temperatures in line with the Legionella risk assessment were not completing their digital logbook or that the cleaning company did not have COSHH risk assessments for all the products they used in the practice until we brought it to their attention during the inspection.</p>	

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the 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.