

Care Quality Commission

Inspection Evidence Table

Pinfold Medical (1-570735489)

Inspection date: 20 and 29 September 2021

Date of data download: 12 August 2021

Overall rating: Good

At the last inspection we rated the practice as overall Requires Improvement because:

- The practice's performance for some of the long-term conditions were below the local and national averages, and the target for cervical cancer screening had not been met.
- There was limited evidence of quality improvement activity.

At this inspection we have rated the practice as overall Good, with the exception of the population group of people experiencing poor mental health which we have rated as requires improvement because:

- There were clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse.
- The practice provided care in a way that kept patients safe and protected them from avoidable harm. There were systems and processes in place for the recruitment of staff in accordance with the regulations.
- We found health and safety, fire safety risk assessment, security risk and infection control assessments had been completed at the practice premises.
- Patients received effective care and treatment that met their needs.
- Staff had the skills, knowledge and experience to deliver effective care, support and treatment. There was clinical oversight and effective systems for quality improvement.
- Although the practice remained below the threshold for long term condition reviews and cervical screening rates they were able to evidence that an action plan was underway to improve outcomes with progress monitoring in place.
- Mental health indicators were below local and national averages which had declined further since our last inspection and action taken had not yet demonstrated improved outcomes.
- The practice adjusted how it delivered services to meet the needs of patients during the COVID-19 pandemic. Patients could access care and treatment in a timely way.
- The way the practice was led and managed promoted the delivery of high-quality, person-centre care.
- The way the practice was led and managed promoted the delivery of high-quality, person-centred care.
- Although our clinical searches identified some issues with high risk medicine management, these issues were not systemic, and the provider demonstrated they had the capacity and capability to address them.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

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 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There was a safeguarding lead and deputy lead in place to oversee safeguarding. • All staff had completed the required level of safeguarding training relevant to their role. This included identification and referral to improve safety (IRIS) training for domestic violence. Staff we spoke with were clear on the procedure to follow if they had a safeguarding concern. • There were safeguarding registers in place which was regularly reviewed and maintained. We reviewed patient records and found they were coded appropriately and contained clear information on their record. • There were comprehensive policies and procedures for safeguarding children and vulnerable adults. These were reviewed and updated to reflect any changes and were accessible to staff. • We reviewed meetings and could evidence that safeguarding concerns were discussed in practice meetings, however this was not a standing agenda item. The practice told us they would action this in future meetings. • Clinicians followed up children and young people who did not attend appointments both at the practice and for secondary care appointments. • Staff files reviewed demonstrated that Disclosure and Barring Service (DBS) checks were in place for staff as part of pre employment checks. This included enhanced and standard DBS checks 	

Safeguarding	Y/N/Partial
<p>based on the role and responsibilities of the job. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.</p> <ul style="list-style-type: none"> Multi-disciplinary meetings were held across the primary care network (PCN) on a weekly basis. The practice were accessing a health visitor through a single point of access during COVID-19 and had plans to host their own safeguarding meetings. The practice could evidence how they had been involved in a serious case review in the past 12 months and had shared lessons learnt with the wider practice team as part of good practice. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We reviewed four personnel files including clinical, non-clinical and recently employed staff. We found all the appropriate checks had been carried out prior to employment such as references, proof of identity and staff vaccinations in line with relevant guidance. Induction checklists were in place for each staff member tailored to their role. 	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: January 2021	Y
There was a record of equipment calibration. Date of last calibration: October 2020	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
A fire risk assessment had been completed. Date of completion: November 2022	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The property was maintained by NHS Property Services. Fire safety policies were in place and evidence was provided of a completed fire risk assessment. A fire evacuation drill was held annually, and fire alarm testing took place each week on a Thursday. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: August 2021	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: August 2021	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Premise and security checks had been reviewed. For example, a review of laptops and mobile phones to ensure they are password protected. • Health & Safety actions had been acted on. For example, ensuring fire marshal training is up to date and carrying out work-based assessments for staff. 	

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: November 2020	Y
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • To ensure the safety of both staff and patients during COVID-19 pandemic, clinical staff were given time between seeing each patient to clean their consulting rooms. • The practice kept up to date with the changing advice and guidance from NHS England to ensure the GP practice offered a Covid Secure environment. • Staff had completed infection prevention training relevant to their role. There was an infection control lead in place, however the lead was new in post and was yet to actively take on this role. As a result, an interim infection control audit had not been undertaken during June 2021. • We observed the general environment to be clean and tidy with the layout and facilities of the premises changed in line with COVID-19 guidance for infection prevention and control. 	

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
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a system in place to manage staff absences. This was managed via an electronic platform and had limits on the number of staff taking annual leave to ensure adequate cover arrangements were in place. • All non-clinical staff were trained in dual roles to ensure staff were skilled in areas of work. • There were induction arrangements in place tailored to individual roles. This included buddy arrangements for permanent and temporary staff. • All staff had undertaken basic life support and sepsis training. There were embedded processes on the system to flag indicators such as wound care, sepsis and those requiring urgent treatment. We saw evidence of sepsis guidance in clinical rooms. 	

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
Referrals to specialist services were documented, contained the required information 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
Explanation of any answers and additional evidence:	

- A system was in place to ensure all patient information including documents, laboratory test results and cytology reports were reviewed and actioned in a timely manner.
- There was a policy and process in place for the summarising of patient records, this included a system for flagging records which required prioritising.
- There was an allocated team in place for managing referrals to specialist services. We saw evidence that referrals had been actioned promptly.
- There was oversight for managing test results. These were assigned to the GP that had requested them. The practice had an effective buddy system to ensure that routine results were re-allocated to another GP in their absence and any urgent results were acted on the same day by the on-call GP.

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) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.91	0.69	0.70	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). (01/04/2020 to 31/03/2021) (NHSBSA)	8.6%	6.9%	10.2%	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 (01/10/2020 to 31/03/2021) (NHSBSA)	5.64	5.13	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	240.6‰	131.9‰	126.9‰	Tending towards variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	0.52	0.70	0.66	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) <small>(NHSBSA)</small>	13.7‰	8.4‰	6.7‰	Variation (negative)

Note: ‰ means *per 1,000* and it is **not** a percentage.

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

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> We discussed the negative variation for the prescribing of pregabalin, gabapentin and psychotropics in comparison to local and national averages. The practice told us that they had high levels of patients registered with mental health issues and could evidence that 60% of this was initiated in secondary services. The practice had undertaken an audit and the pharmacist was leading on pain management and monitoring this through a structured approach. The practice could evidence that 36% of patients were currently on reduction regimes and 4% had their medicines stopped. There was clinical oversight for all requests to medicine changes and a clear process was in place to demonstrate what actions had been taken. During our remote clinical review, we found an issue with some of the monitoring for patients on Lithium. We found that patients were being routinely reviewed, however some patients bloods were overdue, or where routine bloods had been taken, they had overdue calcium or urea and electrolytes tests. The practice told us that some of these patients were under the care of secondary services, however we were unable to evidence this in the patient records and it was not clear if shared care agreements was in place. We also undertook a remote clinical records search of patients prescribed Simvastatin and Amlodipine together. An MHRA safety alert was issued in December 2014 which outlined the increased risk of adverse events when these medicines are taken together. The alert advised that patients on both medicines should be reviewed and one of the medicines should be replaced with an alternative or the Simvastatin dose should be reduced to 20mg. Our remote clinical records search identified that patients were being routinely monitored, However, we was unable to evidence from the records that a review had taken place in accordance with the safety alert. We discussed our findings with the practice who told us there was a system in place to run searches every three months. They recognised that these searches needed to be reviewed further following our review. The practice took immediate action to review those patients requiring further blood tests and reviews. At the time of our inspection the practice confirmed that patients identified had been contacted and the issues raised with clinicians. Emergency medicines and vaccines were appropriately stored and there was clear monitoring processes in place. 	

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:	10

Number of events that required action:	10
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had a significant events monitoring policy and analysis template in place. Staff were encouraged to report incidents to the management team. Significant events and the learning was shared with staff in practice meetings and was a standing agenda item. The practice had a record log of significant events and incidents that had occurred and the learning outcomes. 	

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

Event	Specific action taken
Shingles vaccination out of date.	Medicines were reviewed and discarded. The process for monitoring vaccines was reviewed with staff. A new electronic system was embedded to add an alert as an additional safety layer.
Needlestick injury – lancet was thrown in the bin instead of the sharps box.	Incident was reported to practice manager and occupational health immediately. Processes was reviewed with all staff to ensure sharps bins are located on top of the counters in clinical rooms. Sharps handling policy was reviewed with staff and an audit undertaken to identify when the lancet may have been used.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had a system in place for the recording and acting on safety alerts. This was disseminated amongst the appropriate staff through an electronic platform and discussed in practice meetings. We looked at a range of safety alerts and found the majority of these had been actioned appropriately. However, we found two Medicines and Healthcare products Regulatory Agency (MHRA) alerts had not been fully acted upon for patients who were prescribed Citalopram and aged over 65 and Simvastatin and Amlodipine. We raised this issue with the provider who took immediate steps to ensure that all MHRA alerts would be fully reviewed and acted upon on an ongoing basis. This included placing alerts within their system to run safety searches every two months. During our inspection, the practice provided evidence that those patients we had identified had been contacted and appropriate action taken. 	

Effective

Rating: Good

At the last inspection the practice was rated as requires improvement for effective because:

- There was limited evidence of quality improvement activity.
- People with long term conditions had not received an annual review.
- Cervical screening rates were below national targets.

At this inspection, we have rated the practice as good, with the exception of people experiencing poor mental health which we have rated as requires improvement because:

- The practice were able to evidence a programme of quality improvement activity.
- Although the practice remained below the threshold for long term condition reviews and cervical screening rates, they were able to evidence that an action plan was underway to improve outcomes with progress monitoring in place.
- Mental health indicators were below local and national averages which had declined further since our last inspection and action taken had not yet demonstrated improved outcomes.

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Provider policies and procedures were in place which promoted evidence based practice.• Clinical staff were able to describe how they kept up to date with best practice. We saw evidence that the practice held gold standards framework (GSF) meetings monthly as part of best practice.	

Older people

Population group rating: Good

Findings

- Clinical staff were able to describe how they delivered effective care to older patients. This included working with the local Rapid Response service to ensure older patients can be assessed and treated at home on the same day.
- 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 medicines 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.
- All patients over the age of 75 years were offered a same day appointment.
- 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.

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	77.7%	75.5%	76.6%	No statistical variation

assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)				
PCA* rate (number of PCAs).	1.5% (10)	6.7%	12.3%	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 (01/04/2019 to 31/03/2020) (QOF)	94.0%	88.4%	89.4%	No statistical variation
PCA rate (number of PCAs).	0.8% (3)	8.6%	12.7%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	75.8%	80.6%	82.0%	No statistical variation
PCA* rate (number of PCAs).	2.2% (7)	3.9%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	55.2%	64.0%	66.9%	Tending towards variation (negative)
PCA rate (number of PCAs).	6.1% (30)	11.8%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	52.5%	70.4%	72.4%	Variation (negative)
PCA rate (number of PCAs).	2.7% (33)	5.6%	7.1%	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 (01/04/2019 to 31/03/2020) (QOF)	89.7%	91.9%	91.8%	No statistical variation
PCA rate (number of PCAs).	1.0% (2)	3.7%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	77.1%	72.9%	75.9%	No statistical variation
PCA rate (number of PCAs).	8.0% (39)	8.4%	10.4%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Any additional evidence or comments

- At the previous inspection we found the practice were unable to demonstrate some patients with long term conditions had received the appropriate monitoring as we found that the provider did not have an effective mechanism to follow up on people who had been invited for a long term condition review.
- At this inspection we found, the practice had taken action to implement a new recall system. Invitations were being sent out at regular intervals which was kept under review in line with their overall QoF plan. In addition, clinicians had lead roles to support QoF activity which was supported by monitoring templates. We found that there were still some areas in relation to long term condition which were below local and national averages, however there had been some improvements in relation to asthma and diabetes reviews.

Families, children and young people

Population group rating: Good

Findings

- The practice has met the minimum 90% for all of the childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- 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.
- All children under the age of five years were offered a same day appointment.
- 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) (01/04/2019 to 31/03/2020) (NHS England)	98	104	94.2%	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) (01/04/2019 to 31/03/2020) (NHS England)	92	95	96.8%	Met 95% WHO based target
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) (01/04/2019 to 31/03/2020) (NHS England)	92	95	96.8%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	92	95	96.8%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	95	101	94.1%	Met 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Any additional evidence or comments

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Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had not met the target of 80% for cervical screening. Evidence provided by the practice showed that they were reviewing cervical screening each month to increase uptake further as part of their action plan.
- 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 medicines without the need to attend the surgery.
- The practice used the Our Net Extended Access service. These enabled patients access to an appointment by telephone or face to face between 6.30pm and 9pm during the working week and 10am and 2pm during weekends.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2021) (Public Health England)	71.0%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	65.6%	65.7%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	57.8%	54.9%	63.8%	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 (01/04/2019 to 31/03/2020) (QoF)	100.0%	84.9%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	54.3%	48.0%	54.2%	No statistical variation

Any additional evidence or comments

- At the last inspection the practice were currently below the 80% target for cervical screening. The practice team were aware that their achievement in cervical screening remained below the national target and were currently taking action to review this further each month to increase uptake. This included offering weekend appointments to target patients who were unable to attend during the working week. The practice were able to evidence that during August 2021 they had sent out 346 invites to patients with an uptake of 20% attendance. Unverified data reviewed by the practice indicated that their current achievement to date was 71%.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- There was evidence of Gold Standard Framework (GSF) meetings with members of the multi-disciplinary team to ensure end of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held registers in line with GSF and end of life care which was discussed and reviewed in clinical meetings. End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check. We saw evidence of a social prescribing plan in place with a patient with a learning disability.
- There was a lead GP in place for patients with learning disabilities who undertook annual reviews. The practice also hosted a separate COVID-19 vaccinations clinic for those patients with a learning disability.
- The PCN employed a social prescriber who spent time at the GP practice. This was a popular and useful resource to support patients with social care needs.
- 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: Requires Improvement

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- The practice outcomes for Mental Health was below local and national averages. The practice was working through an action plan to address this further to increase their outcomes further.
- 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 medicines.

- 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.
- All staff had received dementia training in the last 12 months.
- 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 (01/04/2019 to 31/03/2020) (QoF)	54.3%	74.8%	85.4%	Variation (negative)
PCA* rate (number of PCAs).	1.2% (1)	15.8%	16.6%	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 (01/04/2019 to 31/03/2020) (QoF)	18.6%	66.7%	81.4%	Significant Variation (negative)
PCA rate (number of PCAs).	9.1% (7)	9.8%	8.0%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Any additional evidence or comments

- We reviewed mental health indicators and found that overall outcomes had declined since our last inspection. The practice told us they were signed up to the SMI (Serious Mental Illness) local enhanced service to ensure that patients are offered routine health checks and managed more proactively. The practice told us that mental health reviews during COVID-19 had been challenging, in addition to having higher than average prescribing for patients with severe mental health and higher levels of deprivation. As part of their QoF action plan they were continuing to review patients and engage with carers to keep this under review. They continued to have access to a social prescriber to engage with hard to reach groups within their patient population and review prescribing regimes initiated for patients in secondary services.
- We discussed the outcomes for the percentage of patients diagnosed with dementia as this was significantly below the local and national averages. The practice told us that potential coding following a practice merger may have impacted on their low outcomes and would review this further. We found that 61 patients were on the dementia register and 17% had already completed a review. The practice told us that the remainder were in the process of being contacted for a review or home visit. They provided evidence to demonstrate that 27 appointments were booked for reviews throughout October and November 2021. The practice continued to have access to services such as dementia cafes and dementia support groups, however this had been difficult during COVID-19 and there had been delays in accessing services such as memory assessments.

Monitoring care and treatment

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

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	474.8	533.9
Overall QOF score (as a percentage of maximum)	84.9%	95.5%
Overall QOF PCA reporting (all domains)	4.5%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

An audit was carried out to assess if the appropriate hormone replacement therapy (HRT) is being prescribed for patients with menopausal symptoms or early ovarian failure. The audit identified there were 56 patients prescribed HRT and only one had been identified as having a potential problem. A plan was put in place to review this further with the patients. A discussion on the findings were discussed in a clinical meeting and updated on an electronic platform to remind clinicians to check the appropriateness and safety of HRT as part of best practice.
An audit was carried out to assess the number of patients who were taking combined oral contraceptive pill (COCP) and were over the age of 35 years and were smokers. The aim of audit was to improve the safety and quality of COCP prescriptions in the practice. The audit found 7 women identified at potential risk, however there was an 85% compliance rate to demonstrate compliance with national and quality guidelines. The audit was reviewed with clinicians to ensure smoking status is reviewed during contraception reviews.
An audit was carried out to review patient survey results for the practice to monitor performance. The audit found that the practice were in line in most areas of satisfaction in line with local averages. However, where lower areas of performance was highlighted an action plan was taken to address areas such as telephone improvements, review of processes in line with current COVID and engagement with the PPG.

Any additional evidence or comments

At the last inspection we found that there was limited audit activity undertaken. At this inspection we found that there was a regular programme of quality audit now in place This included audits for example:

- QOF Workplan
- 2 week wait referrals
- Quarterly competence checks for ANP's
- Managing face to face patients presenting with respiratory symptoms
- Waiting time for routine appointments
- DOACS and renal functioning cycle
- Review of patient survey results
- PCN – QI prescribing safety
- UTI prescribing
- Flu stock
- Quarterly inadequate smear audit

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.	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
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had a programme of training which was in place and regularly reviewed. Staff had completed core training in areas such as infection control, safeguarding, information governance and basic life support. There was a system in place to send alerts to notify staff of any training which was due to be updated. • We found that some appraisals had been completed throughout the year and others were slightly overdue. The practice told us there had been delays to some appraisals due to COVID-19 in addition to a further practice manager being new in post. However, the practice could evidence that all outstanding appraisals had been booked to take during October 2021. 	

- Non-medical prescribers were provided with clinical supervisors and oversight. The practice were able to evidence that clinical audits were undertaken by a GP every three months to support prescribing practice and competences.

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We saw evidence that the practice worked with multi-disciplinary teams and across the primary care network (PCN) to coordinate care effectively for patients. Gold standard framework (GSF) meetings were being held monthly to review vulnerable patients and end of life 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 and tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had a programme of quality improvement to ensure patients received the appropriate reviews and monitoring. • The practice were engaged in the Primary Care Network and was supported by a social prescriber to support patients in managing their health and wellbeing. 	

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
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y

Well-led

Rating: Good

At the last inspection the practice was rated as Requires Improvement for Well-led services because:

- There was limited evidence of quality improvement activity and audits did not include the number of patients or what quality improvements had been made to treatments or processes.
- Patients told us that they found the signage, two reception desks and two waiting areas confusing, and some patients were unaware the two practices had merged.

At this inspection we rated the practice as Good for Well-led services because:

- The provider had acted to address challenges that had been identified during the last inspection for the signage for the practice.
- There was a programme of audit activity which supported quality improvement.
- The way the practice was led and managed promoted the delivery of high-quality, person-centred care.
- Although our clinical searches identified some issues with high risk medicine management, these issues were not systemic, and the provider demonstrated they had the capacity and capability to address them.

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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• Leaders understood the challenges impacting on the delivery of the service which included access to appointments and the impact of the COVID-19 pandemic. They had taken action to improve patients experience and kept this under review.• Succession planning and development was in place. Since the last inspection, the practice had appointed a new GP partner and a second practice manager. There were lead roles in place to support quality, governance and management. At the time of our inspection, three GP's were currently undertaking a leadership training programme.• At the previous inspection we identified limited audit activity undertaken and lower outcomes in relation to cervical screening and some long term conditions. Despite the challenges faced during COVID-19 the practice had reviewed their audit activity and now had a regular programme of audit in place.	

- We found that the practice had implemented a new system for long term conditions and cervical screening reviews. There was now an effective process in place to strengthen their recall systems, however the action taken had not yet been effective.
- The practice was a member of a primary care network (PCN) and the leadership team were aware of the changing landscape of primary care.

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
Explanation of any answers and additional evidence:	
<p>The practice had a clear vision and aim to provide:</p> <ul style="list-style-type: none"> • High-quality, effective care in a responsive and considerate manner. We aim to enhance the health and well-being of those we care for and to provide a safe and fulfilling working environment. We incorporate technology smartly to improve the efficiency and effectiveness of our administration, patient contacts and clinical activity. We seek to collaborate and work in partnership locally to strengthen our community links and respond to the needs of our patients and actively participate in the development, procurement and implementation of new services. • The vision and strategy was regularly reviewed by leaders weekly to monitor against any performance, risk, and to consider any further planning. Information was shared with staff member on a fortnightly basis where they were given the opportunity to disseminate information and contribute in providing feedback where necessary 	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There was a policy for whistleblowing which allowed staff to understand the process and refer any concerns. • Practice meetings took place which provided an opportunity for staff to discuss issues. • The practice encouraged staff to partake in an annual staff culture survey. 	

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

Source	Feedback
Staff Interviews	<ul style="list-style-type: none"> • Staff told us they enjoyed working at the practice, people are approachable and it runs smoothly. • Staff told us they found it was a busy surgery however staff work well together and feel we are listened to. • Staff told us the practice is very open and strives towards giving good care. They have reviewed the wellbeing of their staff.

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • During this inspection, we found formal systems were in place to monitor the quality of services provided. The practice had implemented monitoring templates to ensure quality indicators were reviewed and there was a structured approach to support the governance arrangements. 	

- Policies and procedures were available on an electronic system which were accessible to all staff. Discussions with staff showed understanding and awareness of key policies such as child and adult safeguarding, infection control and significant events.
- Evidence reviewed from clinical records and discussions with staff demonstrated patients care and treatment was delivered with effective governance structures and systems and clinical oversight. Quality improvement had been strengthened to ensure governance structures were regularly monitored as part of best practice.
- Staff we spoke with were clear about their role and responsibilities. We saw new staff had received a role specific induction.
- We saw that the management team facilitated communication within the practice through an internal meeting structure which included monthly practice and clinical meetings and multi-disciplinary team (MDT) meetings. Minutes of meetings were available for staff.

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 quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had a range of risk assessments in place, for example, fire, health and safety, and infection control. • The practice had arrangements to identify, manage and mitigate most risks, however further improvement was necessary to ensure the risk management of medicines and safety alerts was comprehensive and sufficiently embedded to support high quality care. Following the concerns raised, the practice responded and took immediate action to address medicines management to embed their processes further. • There was a programme of clinical auditing in place to monitor quality and implement improvements. There were systems in place to review the capacity, demand and waiting times to ensure quality and sustainability was regularly assessed and monitored • The practice had a business continuity plan in place which was accessible to all staff electronically. 	

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • All patients that requested to see a GP were first given a telephone appointment. Following the telephone review, the GP would make a clinical decision if a face to face appointment was required. • Infection control processes had been strengthened and extra cleaning schedules had been implemented to ensure cleaning was carried out at frequent intervals. Clinical staff were given extra time between patients to clean their consultation rooms. COVID-19 risk assessments had been completed for each member of staff. 	

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 monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice could evidence they had systems and processes established to regularly review information and performance. This included the use of the Quality and Outcomes Framework (QOF), audits and action plans to improve clinical performance and outcomes for patients. 	

- Systems were in place to ensure risk assessments were completed on a regular basis to manage and mitigate risks.

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Explanation of any answers and additional evidence:	

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.	Partial
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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">At the previous inspection, we found that following a practice merger with a practice in the same building, signage was not clear for new patients who wished to register and patients we spoke with told us that they found the use of three names very confusing.At this inspection, we found that the practice had taken steps to address visible signage and make it more clear that it was operating under one practice. As the property was owned by NHS Property Services the practice were restricted on amending some of the visible signage; however we could see evidence that the practice had adapted where possible and taken steps to ensure this was more clear for patients entering the building.The practice told us there had been no active patient participation meetings (PPG) during COVID-19, however they still had ongoing engagement with the PPG chair for feedback. For example, feedback on changes to the appointment system during COVID-19. They continued to engage with Healthwatch on any issues or concerns about the service from patients.	

Continuous improvement and innovation

There were evidence of 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">The practice were continuing to engage within the Primary Care Network (PCN) and were currently reviewing cancer referrals and sharing best practice.The practice was currently reviewing extended access during the weekend and evening to improve access for working age people and those unable to attend during the working week. They were currently in the process of integrating the out of hours service into their system so this could be more streamlined; this service included offering blood tests during the weekend.	

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.
- *PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
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- ‰ = per thousand.