

Care Quality Commission

Inspection Evidence Table

Highcroft Surgery (1-542061967)

Inspection date: 14/06/2021 – 17/06/2021

Date of data download: 28 June 2021

Overall rating: Good

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 ¹ |
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Y ² |
| There were policies covering adult and child safeguarding which were accessible to all staff. | Y |
| Policies and procedures were monitored, reviewed and updated. | Y ³ |
| 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 ⁴ |
| Explanation of any answers and additional evidence: | |
| 1. Staff we spoke to demonstrated they were aware of the safeguarding leads for both children and adults and the relevant issues to raise with the leads. | |

| Safeguarding | Y/N/Partial |
|--|-------------|
| 2. During the COVID-19 pandemic, the practice received national guidance on safeguarding procedures. This included sending letters to vulnerable patients, carers and guardians on how they could access GP services and support during the pandemic and periods of national lockdown. Policies and procedures were reviewed in line with national guidance and staff were alerted to changes. | |
| 3. The practice used a clinical decision support system, integrated into their clinical system. The system had local and national guidance embedded within it and updated automatically to ensure accurate and up to date information was always available to clinicians. This included safeguarding resources such as alerts and prompts to complete risk assessments, which assured them that they were following best practice. | |
| 4. Records reviewed as part of the inspection showed safeguarding records were updated regularly and there was continued engagement with other health and social care professionals throughout the COVID-19 pandemic. | |

| Recruitment systems | Y/N/Partial |
|---|----------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Y ¹ |
| 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 |
| Explanation of any answers and additional evidence: | |
| 1. We reviewed five staff files during the inspection which demonstrated all the relevant recruitment checks had been undertaken. | |

| 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: March 2019 | Y |
| There was a record of equipment calibration. Date of last calibration: March 2019 | Y |
| There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. | Y |
| There was a fire procedure. | Y |
| A fire risk assessment had been completed. Date of completion: November 2018 | Y |
| Actions from fire risk assessment were identified and completed. | Y |
| Explanation of any answers and additional evidence: | |

The practice told us the portable appliance testing and equipment calibration was due in March 2020; but postponed by another year due to the COVID-19 pandemic, with appropriate risk assessments in place.

| Health and safety | Y/N/Partial |
|---|-------------|
| Premises/security risk assessment had been carried out. Date of last assessment: 13/06/2021 | Y |
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: December 2020 | Y |
| Explanation of any answers and additional evidence: We saw records of water quality testing as part of a legionella risk assessment. COVID-19 risk assessments were introduced to protect staff who may be at higher risk of infection. | |

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met/not 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: 13/11/2020 | Y |
| The practice had acted on any issues identified in infection prevention and control audits. | Y ¹ |
| 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: | |
| 1. The practice purchased an additional fridge for storage of vaccines in anticipation of flu and COVID-19 vaccines, an action identified in the infection prevention and control audit. | |

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 ¹ |
| There was an effective induction system for temporary staff tailored to their role. | Y ² |
| 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 |
| Explanation of any answers and additional evidence: | |
| 1. Leaders were aware of areas where there were backlogs, this was as a result of changing their ways of working during the COVID-19 pandemic, in line with national guidelines. Temporary staff had been employed for a period, and there were active recruitment advertisements for more staff at the time of our inspection. | |
| 2. Additionally, induction programmes were tailored to suit specific job roles, including temporary staff such as locum GPs. | |

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 ¹ |
| 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: <ol style="list-style-type: none">1. At the time of our inspection, there were approximately 650 new patient notes waiting to be summarised. This represented about 5% of their patient list size. The practice told us they prioritised records for vulnerable patients whilst they recruited staff who were able to carry out notes summarising. | |

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) | 0.71 | 0.70 | 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) | 11.3% | 9.1% | 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) | 4.47 | 4.62 | 5.37 | Tending towards variation (positive) |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA) | 98.6‰ | 127.4‰ | 126.9‰ | No statistical variation |
| 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) | 0.47 | 0.56 | 0.66 | No statistical variation |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA) | 6.4‰ | 6.1‰ | 6.7‰ | No statistical variation |

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 ¹ |

| Medicines management | Y/N/Partial |
|--|----------------|
| 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 ² |
| 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 ³ |
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services. | Y |
| There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. | Y ⁴ |
| 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 |
| <p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. We saw evidence of signed patient group directions authorising nursing staff to carry out specific vaccinations and confirming they were suitably trained to do so. 2. Non-medical prescribers told us they had debriefing sessions to ensure they were seeing patients within the scope of their practice and they were included in prescribing audits. 3. We saw evidence that the practice were working with the CCG's medicines optimization team to review their processes for repeat prescribing to improve safety. 4. We carried out a clinical review of patients on high risk medicines (lithium and novel anticoagulants, also known as NOACs) and disease modifying antirheumatic medicines (methotrexate and azathioprine). We found: <ul style="list-style-type: none"> • Two of out 43 patients identified by search on methotrexate who potentially had not had required monitoring. A further analysis showed one of these was receiving the appropriate monitoring through the hospital. • Three out of seven patients identified by search on azathioprine who potentially had not had required monitoring. A further analysis indicated there were no concerns in the management of these patients. | |

| Medicines management | Y/N/Partial |
|--|-------------|
| <ul style="list-style-type: none"> • Five out of seven patients identified by search on lithium who potentially had not had required monitoring. A further analysis indicated there were no concerns in the management of these patients. • 39 out of 227 patients identified by search on NOACs who potentially had not had required monitoring. Creatinine clearance was not being calculated as per guidance when prescribing NOACs. By not doing this, there was a risk that the dose prescribed may be too high or too low, and this creates a potential risk of haemorrhage or thrombosis. <p>The practice immediately reviewed the findings and took the necessary actions to ensure safety and no patients were missed to follow up where appropriate.</p> | |
| | |

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: | 20 |
| Number of events that required action: | 20 |
| Explanation of any answers and additional evidence: There were 20 significant events recorded between May 2020 and May 2021; all relevant actions had been completed. | |

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

| Event | Specific action taken |
|---|--|
| An appointment request was entered on the online appointments and requests system for a patient under 16 years of age, but the person entering it did not complete the entry and submit it. | All online appointments and requests regarding children are now highlighted in red on the list and prioritised for action and follow up. Staff received additional training to ensure they were aware of this. |
| Incorrect blood tests taken for a patient after two patients attended at the same time, and confirmed incorrect identification details | Apologies were given and appointment rebooked for the correct bloods. Staff were advised to carry out a minimum of three identification checks to avoid recurrence as it is possible for people to have the same name and date of birth. |

| Safety alerts | Y/N/Partial |
|---|-------------|
| There was a system for recording and acting on safety alerts. | Y |
| Staff understood how to deal with alerts. | Y |
| Explanation of any answers and additional evidence: We saw examples of actions taken on recent alerts for example, <ul style="list-style-type: none"> An alert had been issued in 2020 regarding a supply disruption of lithium carbonate tablets. The practice found six patients who were on the medicine and took the appropriate action by alerting all GPs and checking the patients had adequate supplies. An alert had been issued in 2014 regarding patients over 65 years of age on citalopram, who were at risk of heart problems when doses higher than 40mg were given. There was evidence of some actions taken by the practice but these needed to be strengthened to effectively mitigate risks. The practice reviewed and completed these soon after the inspection in line with recommended guidance. | |

Effective

Rating: Good

Effective needs assessment, care and treatment

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

| | Y/N/Partial |
|--|-------------|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice. | Y |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Y |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. | Y |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Y |
| Patients' treatment was regularly reviewed and updated. | Y |
| There were appropriate referral pathways to make sure that patients' needs were addressed. | Y |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Y |
| Explanation of any answers and additional evidence: The CQC received feedback from several patients and their relatives stating they were not followed up in a timely way, and some of them subsequently deteriorated. They stated that they did not get a call back from the practice or received it in the evenings after seeking help in the morning and that the telephone access was poor. Records reviewed as part of the inspection did not find concerns regarding symptoms of serious illness which were not acted on in a timely way. There was evidence of safety netting advice given to patients. However, the practice was aware of the problems patients experienced with using their telephones and the online appointments and requests system. At the time of our inspection, the practice had purchased a new telephone system to resolve the issues identified which was due to be installed within a month. | |

Older people

Population group rating: Good

Findings

- The practice provided primary medical services to 124 residents living in three local care homes. A weekly care home ward round was held in person or virtually, led by the advanced nurse practitioner, supported by staff from the primary care network (PCN) and community health staff to support the needs of the residents.
- Feedback we received from a care home was positive about the support received from the practice during the COVID-19 pandemic, particularly when urgent visits or reviews were required. They were positive about the multi-disciplinary team who worked together to meet the medical needs of their residents.

- 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. There was a process for following up those who did not respond to invitations for review.
- 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. Multi-disciplinary meetings were held with other healthcare professionals to improve support and outcomes for patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- The practice identified 1,100 patients over 75 years old. Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles, pneumonia and COVID-19 vaccinations were offered to relevant patients in this age group, including those housebound and living in residential homes.

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. Multiple conditions are reviewed at one appointment, and consultation times are flexible to meet each patient's specific needs. The clinical decision support system used within the practice provided a suite of templates which enabled effective management of patients with multiple conditions.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. A local diabetes nurse specialist supported the practice to undertake joint clinics remotely with the practice nurse to review patients with more complex needs and undertook the initiation of insulin treatment in the community.
- During the COVID-19 pandemic the practice continued to provide reviews and appropriate support remotely via video and telephone consultations and face to face if needed. Wound care continued to be provided in face to face clinics during the pandemic.
- Since April 2021, healthcare assistants carried out home visits to vulnerable and elderly patients with long term conditions to support their reviews where appropriate.
- 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.
- 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 assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF) | 77.2% | 78.9% | 76.6% | No statistical variation |
| PCA* rate (number of PCAs). | 15.7% (135) | 10.7% | 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) | 95.5% | 89.1% | 89.4% | No statistical variation |
| PCA rate (number of PCAs). | 12.9% (23) | 11.6% | 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) | 77.4% | 81.7% | 82.0% | No statistical variation |
| PCA* rate (number of PCAs). | 1.9% (5) | 4.8% | 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) | 57.8% | 65.0% | 66.9% | No statistical variation |
| PCA rate (number of PCAs). | 6.4% (34) | 14.7% | 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) | 78.5% | 72.6% | 72.4% | No statistical variation |
| PCA rate (number of PCAs). | 4.1% (44) | 6.5% | 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) | 97.8% | 94.7% | 91.8% | Variation (positive) |
| PCA rate (number of PCAs). | 11.2% (23) | 5.7% | 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) <small>(QoF)</small> | 71.7% | 73.1% | 75.9% | No statistical variation |
| PCA rate (number of PCAs). | 5.9% (31) | 10.1% | 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

The practice told us some reviews could not be completed in March 2020 due to the COVID-19 pandemic as they had to make changes to operations for consultations and set up as a clinical management centre for their primary care network (PCN). With regards to personalised care adjustments, they found that patients who had not attended when called for review on two occasions were exempted automatically by their clinical system. They told us they planned to review all patients with long term conditions requiring a review on a monthly basis, including those who may have been exempted automatically by the clinical system.

Findings

- The practice has met the minimum 90% for four of the five childhood immunisation uptake indicators. The practice has met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for one of five childhood immunisation uptake indicators. Practice supplied information indicated the practice had achieved 95.8% for children aged 5 who have received immunisation for measles, mumps and rubella (MMR) in 2020/2021. This data is yet to be verified and published.
- The practice contacted the parents or guardians of children due to have childhood immunisations. They told us they continued to carry out newborn and six-week baby checks in face to face appointments throughout the COVID-19 pandemic.
- 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 practitioners (formerly known as health visitors) when necessary, who were based in the same building as the practice.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception through nurse-led clinics offered at the practice.
- 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) | 110 | 116 | 94.8% | 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) | 107 | 116 | 92.2% | Met 90% minimum |
| The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England) | 107 | 116 | 92.2% | Met 90% minimum |
| 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) | 107 | 116 | 92.2% | Met 90% minimum |
| 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) | 106 | 129 | 82.2% | Below 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

Practice supplied information indicated the practice had achieved 95.8% for children aged 5 who have received immunisation for measles, mumps and rubella (MMR) in 2020/2021. This data is yet to be verified and published

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice offered patients the choice of booking appointments by telephone or online using the NHS total triage model. The online appointments and requests system was available throughout the week including weekends during the pandemic and reduced to weekdays as the national restrictions on movements eased.
- Extended hours appointments with GPs and the nursing team were available on two evenings each week until 8 pm. Flu and Covid vaccination clinics were offered at weekends and in the evening to improve access to vaccinations for working patients.
- Patients had access to appropriate health assessments and checks. The NHS checks for patients aged 40 to 74 had been ceased during the pandemic but the practice told us they had plans to resume the checks.
- There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. patients who did not return screening tests for bowel cancer were follow up.
- The practice set up a self health monitoring kiosk for patients within the building to monitor their own self-care and provide opportunistic screening. Patients could take measurements such as their height, weight, blood pressure and pulse rate prior to their appointments and the data would be transferred directly to their records.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery. Repeat prescriptions could be collected directly from the patients' preferred pharmacies.

| 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: 31/12/2020) (Public Health England) | 76.4% | 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) | 73.3% | 72.5% | 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) | 66.4% | 64.2% | 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) | 85.1% | 90.8% | 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) <small>(PHE)</small> | 56.2% | 52.8% | 54.2% | No statistical variation |
|--|-------|-------|-------|--------------------------|

Any additional evidence or comments

Practice supplied data showed they achieved 80.55% for cervical screening in 2020-21. This data is yet to be verified and published.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- All patients with a learning disability were offered an annual health check. There were 70 patients identified on the learning disabilities register in 2020-2021, and 59 of them had received an annual health check.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule. They told us they had administered 1,408 COVID vaccinations to patients who were vulnerable, housebound or living in care homes; the highest number of vaccinations achieved by a practice within their PCN. This had been achieved through offering additional clinics at weekends and home visits for those who were housebound.
- Patients who were considered suitable for shielding to protect them from COVID-19, in accordance with the NHS guidelines, were contacted and followed up. The practice supplied monitoring kits to support the management of those who were identified as acutely ill from COVID-19 to ensure that early signs of deterioration were acted on, and they could be managed within the community reducing the need for hospital admissions.
- Carers and bereaved patients were offered extensive support particularly during the pandemic. There were two carers champions within the practice who proactively contacted carers and signposted them to advice and support services. There were 249 carers identified by the practice (2.1% of their practice list).
- Additionally, the nursing team set up a food bank during the pandemic to support people in need and carried out personal shopping for vulnerable people.
- Vulnerable people were offered video consultations, telephone appointments and face to face appointments where necessary during the pandemic.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- During the pandemic the practice introduced an online appointments and requests system. The system allowed patients to complete screening questionnaires which flagged patients with severe mental health problems and risks of self-harm.
- 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.
- There was a lead clinician for dementia within the practice. All staff had received dementia training.
- 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) <small>(QOF)</small> | 88.7% | 81.1% | 85.4% | No statistical variation |
| PCA* rate (number of PCAs). | 43.0% (40) | 20.7% | 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) <small>(QOF)</small> | 84.6% | 82.6% | 81.4% | No statistical variation |
| PCA rate (number of PCAs). | 3.3% (4) | 8.7% | 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

A review of the personalised care adjustments for mental health indicators found these had been undertaken appropriately during the COVID-19 pandemic.

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) | 544.6 | 533.9 |
| Overall QOF score (as a percentage of maximum) | 97.4% | 95.5% |
| Overall QOF PCA reporting (all domains) | 5.2% | 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 ¹ |

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

We saw examples of several clinical audits undertaken by the practice in the last year, in conjunction with pharmacists employed by the PCN and/or CCG in areas such as end of life care, controlled drugs, prostate cancer, Non-steroidal anti-inflammatory drugs (NSAIDS) and anticoagulants. However, these were one cycle audits which were yet to be repeated to show improvements had been embedded.

The audits carried out by medical students were done to facilitate their learning but also focused on areas relevant to the practice, for example, patients of child-bearing age taking sodium valproate. A re-audit was planned to show improvement in compliance with recommended monitoring guidance.

Any additional evidence or comments

1. Emergency admissions data supplied by the practice showed that from June 2019 to May 2020 they achieved lowest admission rates in comparison to two local practices, and their rates were lower than their PCN rates.

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 ¹ |
| Staff had protected time for learning and development. | Y |
| There was an induction programme for new staff. | Y ² |
| 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 ³ |
| 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 ⁴ |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Y |
| <p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. Staff spoke highly about the support they had received in undertaking additional training suitable for their roles as well as progressing within the practice. They told us they were given time to undertake training and nursing staff collaborated with external staff to establish mentoring arrangements. 2. The practice worked alongside other healthcare professionals (for example, physiotherapists, pharmacists and paramedics) who were employed through their PCN to provide support across a group of practices. We saw evidence of an extensive induction for one such physiotherapist at the surgery. 3. Staff appraisals were carried out annually. However, the practice told us some appraisals were overdue because of a change in management within the practice. There were plans to undertake these as soon as it was practically possible. 4. There were regular clinical debrief sessions for non-medical prescribers and audits were used to monitor performance in line with recommended guidelines. | |

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:

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 |
| <p>Explanation of any answers and additional evidence:</p> <p>The practice set up a self health monitoring kiosk for patients within the building to monitor their own self-care and provide opportunistic screening. Patients could take measurements such as their height, weight, blood pressure and pulse rate prior to their appointments and the data would be transferred directly to their records.</p> <p>Additionally, the nursing team set up a food bank during the pandemic to support people in need and carried out personal shopping for vulnerable people.</p> | |

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 ¹ |
| Explanation of any answers and additional evidence: <ol style="list-style-type: none">1. Consent and mental capacity were embedded into ReSPECT forms. Our remote searches indicated that DNACPR/ReSPECT forms were filled in appropriately. Discussions were documented in records with mention of other appropriate persons being present (ReSPECT is the Recommended Summary Plan for Emergency Care and Treatment. The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices). | |

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels. Leaders could 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. | 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: <p>The practice is a member of a local Primary Care Network (PCN) who work together to improve patient access to services. The practice told us they work collaboratively with other practices within the PCN on delivering local priorities and met regularly.</p> <p>The practice had to change their way of working since the beginning of the COVID-19 pandemic in line with the NHS guidance and standard operating procedures by working to a COVID-19 action plan. This included introducing a total triage system for all patient contacts through online services for accessing appointments, telephone and video appointments.</p> <p>Practice leaders were aware of increased demands on their telephone lines with increasing complaints from patients failing to access the practice via telephone at a time when patients were advised not to attend the practice in person, in line with guidelines. The leaders worked with the providers of the telephone system, commissioned by the clinical commissioning group, but there were no solutions found despite their efforts. The partners subsequently purchased their own telephone system which is due to be installed and operational in September 2021. Additional staff (clinical and non-clinical) were being recruited to provide more capacity to meet the increased demands.</p> <p>At the time of our inspection, the practice leaders were due to meet with the local councillors and member of parliament, together with the Local Medical Committee, to discuss the challenges in delivering services.</p> <p>Leaders expressed how proud they were of how hard their staff worked since the beginning of the pandemic despite the challenges in changing how they worked and the pressures from increasing patient demands, including abuse of their staff. Staff wellbeing was a major concern for them, and they were working on providing appropriate support for their staff.</p> <p>Staff we spoke to told us they felt able to speak to the leaders. They told us the practice manager, although new in post, was approachable and supportive during a difficult period in delivering health services.</p> <p>The partners were aware of potential retirement of some of their staff, including the partners as well. Recruitment was in progress and there was evidence of training and developing staff for multiple roles, including progression, to build resilience within the team.</p> | |

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: | |

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 ¹ |
| 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. | N ² |
| Staff had undertaken equality and diversity training. | Y |
| <p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. The practice kept a record of both formal and informal complaints. Efforts were made to resolve complaints as soon as they were made where possible. One of the partners led on complaints whilst the new practice manager's training was in progress. At the time of our inspection, there had been a delay in acknowledging and investigating some complaints. We reviewed some complaints as part of the inspection which demonstrated the practice responded in an open and honest approach. 2. Some of the staff members we spoke to told us they felt able to raise concerns; however, they were not aware of who their Speak Up Guardian was. Whilst they were aware of how to access their whistleblowing policy if they needed to, the policy did not specify who the local Freedom to Speak Up Guardian is. | |

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

| Source | Feedback |
|--|---|
| Staff interviews and feedback submitted to the CQC | <p>There was positivity about the new management and staff felt leaders were approachable and supportive, particularly with issues not related to work which were affecting them.</p> <p>Whilst some staff have felt they have received support above and beyond from managers and leaders, some felt pressured to take on extra work and that changes have been constant and not communicated well since the beginning of the COVID-19 pandemic.</p> |

| | |
|--|---|
| | Staff felt disappointed by the abuse directed at them by some patients and were aware of the negative feedback on social media websites regarding the challenges with access. They felt they were doing their best to support patients and were looking forward to the new telephone system ensuring a better service for patients. |
|--|---|

Governance arrangements

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

| | Y/N/Partial |
|--|-------------|
| There were governance structures and systems which were regularly reviewed. | Y |
| Staff were clear about their roles and responsibilities. | Y |
| There were appropriate governance arrangements with third parties. | Y |
| Explanation of any answers and additional evidence: | |
| There was a list of designated leads for areas such as safeguarding, infection prevention and control and prescribing, including the nominated staff who supported the leads. Additionally, there were various meetings held and minuted for specific topics or staffing groups to reinforce roles and responsibilities. | |

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. | Y |
| A major incident plan was in place. | Y ¹ |
| 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: | |
| 1. During the pandemic, the practice business continuity plan was amended to include daily reports of their workforce status to the CCG to enable them and the local PCNs to monitor pressures across all GP practices and re-distribute staff as needed. | |

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 ¹ |
| The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access. | Y ² |
| There were systems in place to identify and manage patients who needed a face-to-face appointment. | Y ³ |
| 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 ⁴ |
| 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 |
| <p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. We received a significant number of concerns about the practice from patients in April and May 2021, which were mainly about access to appointments. The practice had changed its appointments system in line with national guidance during the pandemic. This led to increased usage of telephones by both the practice and patients, and subsequent problems with their telephone system struggling to cope with the demand. At the time of our inspection, a new telephone system was due to be installed to mitigate this. Appointments could be requested online. We saw records showing staff were trained on how to use the system and respond to patient requests. Practice supplied data showed that 668 people had visited the online system in the week ending 13 June 2021, and 285 had submitted a request through the system. 2. Patients who did not have access to online services could still access the practice via telephone. The practice was aware of increasing negative feedback regarding their telephones and worked with their supplier to try various solutions to improve telephone access. We saw records showing staff received further training on the telephone system as part of the process. 3. Appointments information supplied by the practice showed that in May 2021, they saw 1,873 in face to face appointments and carried out 118 home visits. Overall, the practice told us they offered 27 more appointments per 1,000 patients per week than a widely considered average. 4. The practice implemented a workflow management system where administration staff were trained to process incoming clinical correspondence. This freed up some hours for clinical staff to deal with more complex cases and built resilience within the team. In response to a backlog of letters that had built up during the pandemic, the workflow team worked with the partners in managing this workload. | |

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: We saw evidence of data collected on online appointments and requests system and how this was reviewed at meetings to drive performance. | |

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: A home working policy was in place for staff who worked from home during the pandemic. This included the relevant information governance, data protection and confidentiality procedures. | |

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 ¹ |
| The practice had an active Patient Participation Group. | Partial ² |
| Staff views were reflected in the planning and delivery of services. | Y ³ |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Y |
| <p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. The practice responded to comments posted on NHS Choices website and encouraged patients to contact the practice to discuss their individual care. Patients using the online appointments and requests system were asked to complete an optional survey a week after using the service. The practice leaders reviewed feedback at meetings with the reception supervisors and acted on concerns raised. 2. The practice's Patient Participation Group (PPG) had not met since the beginning of the COVID-19 pandemic and there were no virtual communications. The practice told us they were looking to re-engage with the group as the national restrictions were lifted. 3. Staff questionnaires were recently introduced as a means of obtaining views from staff on what could be improved in service delivery. Whilst the response was low, managers considered other options of obtaining staff views through suggestion boxes and more regular whole staff meetings. | |

Feedback from Patient Participation Group.

| Feedback |
|---|
| We did not contact members of the PPG as part of this inspection. |

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 ¹ |
| Learning was shared effectively and used to make improvements. | Y ² |
| <p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. We saw examples of several clinical audits undertaken by the practice in the last year, including those undertaken by pharmacists attached to the practice. 2. There was a comprehensive log of significant events, including complaints, which showed learning shared across the team. | |

Examples of continuous learning and improvement

Highcroft Surgery is a training practice for GP Registrars (qualified doctors training to become GPs) and medical students still training at university. One of the partners is a qualified trainer whose status was recently renewed until 2025. They also provide training to nurses who are still at university and supervision. This fosters a learning environment and culture within the practice.

The practice told us one of the senior GPs, a navy veteran, is setting up ex-military service support for ex-service personnel struggling with transition from military to civilian life.

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.
-
- ‰ = per thousand.