

# Care Quality Commission

## Inspection Evidence Table

**Dr. D. Colvin & Dr. O. B. Isinkaye (1-542228265)**

Inspection date: 09 September 2021

Date of data download: 07 September 2021

### Overall rating: Good

At the previous inspection in September 2019 we rated the practice as requires improvement overall. This was due to systems and processes to ensure good governance that required strengthening. At this most recent inspection the practice was rated as good overall. We rated the safe key question and the population group long-term conditions as requires improvement. The practice had driven improvement, but further work was required to strengthen some systems. .

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

### Safe

### Rating: Requires Improvement

At the previous inspection the practice was rated good for providing safe services. At this inspection the practice was rated requires improvement. Although at this inspection, we identified areas of improvement in different aspects of this key question; there were areas where improvements were identified. In particular, the process to check immunisation of staff required strengthening and the practice did not always have oversight and monitoring of identified risk and actions.

#### 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

<b>Safeguarding</b>	<b>Y/N/Partial</b>
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"> <li>• Staff had completed safeguarding training appropriate for their roles.</li> <li>• All staff members had a disclosure and barring service (DBS) check in place.</li> <li>• Staff we spoke with were able to identify the safeguarding leads.</li> <li>• We saw evidence of information available to staff to assist in signposting to external providers.</li> <li>• Staff trained as Chaperones were able to describe their roles and responsibilities clearly.</li> </ul>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
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.	Partial
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: <ul style="list-style-type: none"> <li>• At our inspection we saw evidence that staff vaccinations and immunity levels were checked on induction and discussed during staff appraisals. Following our inspection, a review of non-clinical staff identified a number of staff were not up to date with routine immunisations. The provider submitted evidence of a staff immunisation policy and an action plan in place to mitigate the risk to staff and patient safety.</li> <li>• We reviewed one staff file during the inspection and saw evidence that recruitment checks had been undertaken.</li> </ul>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 29 April 2021	Y
There was a record of equipment calibration. Date of last calibration: 29 April 2021	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: 4 May 2021	Y

Actions from fire risk assessment were identified and completed	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• A Control of Substances Hazardous to Health (COSHH) risk assessment was in place with completed data sheets for all cleaning chemicals used within the practice.</li> <li>• The provider employed an external company to carry out their fire risk assessments. At the time of the inspection the provider was unable to provide assurances that all risks identified had been addressed.</li> <li>• Staff told us fire drill training had been delayed due to the COVID-19 pandemic, we saw evidence that a plan was in place for the training to be undertaken.</li> </ul>	

<b>Health and safety</b>	<b>Y/N/Partial</b>
Premises/security risk assessment had been carried out. Date of last assessment: September 2021	Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Not dated	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• On the day of the inspection we saw limited evidence that premises/ security risk assessments had been undertaken. Following our inspection, the provider submitted additional evidence in place to reduce and manage the risks identified. The provider employed an external company to carry out their health and safety risk assessments. On the day of the inspection we saw evidence of actions identified. During the inspection the provider was unable to gather all the evidence required to provide assurances that the risks identified had been addressed. Following our inspection, the provider submitted additional evidence in place to reduce and manage the risks identified.</li> </ul>	

## Infection prevention and control

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

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: Evidence seen but not dated	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>We reviewed the provider's training matrix and found all members of the team had completed infection control training.</li> <li>We saw evidence of appropriate hand washing facilities and adequate provision of personal protective equipment (PPE)</li> <li>We saw evidence of completed infection prevention and control audits, however the date of the audits was not always documented. Actions identified in the infection control audits had been addressed and discussed at staff meetings.</li> </ul>	

## Risks to patients

### There were adequate systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	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"> <li>Staff told us they had been trained to take on additional roles and had extended their hours in order to meet patient demand and to ensure there was an effective approach to managing busy periods during extended staff absences. We saw evidence of a recruitment plan in place.</li> <li>All staff had received the appropriate training in how to deal with an emergency.</li> <li>Systems were in place to ensure emergency medicines and equipment were checked on a regular basis. Actions had been identified and plans were in place to purchase additional emergency resuscitation equipment.</li> </ul>	

## Information to deliver safe care and treatment

### Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
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: <ul style="list-style-type: none"><li>• During our remote searches, evidence confirmed that the provider had an effective process for summarising patients' notes.</li><li>• We reviewed the management of test results and found that results were documented in a timely manner. During the inspection we saw evidence that a protocol for the management of test result had been put in place for both permanent and temporary staff.</li></ul>	

## Appropriate and safe use of medicines

### The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.69	0.79	0.69	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2020 to 30/06/2021) (NHSBSA)	9.9%	11.8%	10.0%	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 (01/01/2021 to 30/06/2021) (NHSBSA)	6.32	6.04	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	71.1‰	85.7‰	126.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	0.47	0.48	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	4.2‰	6.2‰	6.8‰	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

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.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Since the last inspection the provider had introduced a process to review high-risk medicines.</li> <li>• Remote searches carried out by the inspection team showed medicine management was mainly carried out in line with national recommended prescribing guidance.</li> <li>• Since the last inspection the provider had recruited additional supportive roles through the Primary Care Network (PCN), including a clinical pharmacist. The practice told us that structured medicines reviews had been completed by the clinical pharmacist throughout the pandemic.</li> </ul>	

## 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.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Partial
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	7
Number of events that required action:	7
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Learning events viewed prior to our inspection outlined the date, brief description and summary of action taken. During our on-site visit we reviewed the process of learning and actions taken to reduce the risk of reoccurrence. The provider was unable to demonstrate a consistent approach to ensuring actions had been followed up and closed. Following our inspection, the provider submitted evidence of a revised 'Significant Event Review' form which allowed details of actions to be monitored.</li> <li>We saw evidence of learning events discussed at staff meetings and staff we spoke to demonstrated awareness of learning; however, the practice did not have a process in place to submit significant events to a national database designed to improve learning nationally.</li> <li>On the day of the inspection we saw evidence of an incident reporting policy in place, however this did not contain reference to supporting the recording of a duty of candour notification. Following our inspection, the practice submitted evidence demonstrating that the policy had been updated to encourage a culture of candour, openness and honesty.</li> </ul>	

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

Event	Specific action taken
Car accidentally driven into the front of the surgery wall when staff were in the building.	Business continuity plan put in place, and services moved to another building. Support provided by the local Clinical Commissioning Group.
Patient pulled on ladders in the practice to get up from the chair.	Ladders relocated away from patients reach.

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:

At our last inspection we found:

The lack of an effective patient safety and medicines alert system. The practice maintained a handwritten spreadsheet of Medicines and Healthcare products Regulatory Agency alerts and the clinician was required to initial this spreadsheet once they had received the alert; however there were four clinicians regularly working at the practice but often, there was only two signatures, indicating that this had not been read by all clinicians.

At this inspection we found:

The practice had implemented a new safety alert process. All alerts had been logged into a central system and alerts had been circulated to the relevant clinicians. The practice told us the process had been managed centrally by the Clinical Pharmacist; audits and actions had been completed; and we saw evidence that alerts had been discussed at staff meetings.

## Effective

## Rating: Good

At our previous inspection we rated the practice as requires improvement for providing effective services because not all staff had received appropriate training or an appraisal for their performance, changes to clinical guidance was not being cascaded to relevant staff, cancer screening data had been low over time in relation to national targets, pre-diabetic patients were not being identified effectively.

At this inspection we rated the practice as good for providing effective services, there was a system in place to manage staff appraisals, systems had been strengthened to routinely monitor the effectiveness and appropriateness of care. We did, however, rate the population group long-term conditions requires improvement as data was below local and national averages in some areas.

### Effective needs assessment, care and treatment

**Patients' needs 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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection we found: Changes to guidelines were discussed at clinical meetings, although this was not a standing item on the agenda. We did not see any evidence of NICE guidance being discussed in meeting minutes.</p> <p>At this inspection we found: NICE guidance was now a standing agenda item at clinical meetings. We saw evidence of minutes to demonstrate compliance. Evidence gathered during our remote searches indicated that clinicians predominately followed evidence-based practice and guidelines.</p>	

## Older people

## Population group rating: Good

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual 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.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

## People with long-term conditions

## Population group rating: Requires Improvement

### Findings

- On the day of inspection, we found that some data was below local and national averages. However, we were satisfied with the explanation from members of the management and nursing team about this data. We were assured that there was an action plan in place to improve.
- 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, where clinically appropriate.
- Patients with asthma were offered an asthma management plan.
- We saw evidence of information available to staff to support referrals to relevant professionals.

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)	63.8%	78.0%	76.6%	Tending towards variation (negative)
PCA* rate (number of PCAs).	2.3% (6)	14.8%	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)	90.6%	88.8%	89.4%	No statistical variation
PCA rate (number of PCAs).	14.5% (9)	12.6%	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)	72.7%	79.8%	82.0%	Tending towards variation (negative)
PCA* rate (number of PCAs).	6.6% (7)	4.0%	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)	53.9%	65.1%	66.9%	Tending towards variation (negative)
PCA rate (number of PCAs).	3.5% (6)	18.2%	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)	60.4%	70.8%	72.4%	Tending towards variation (negative)
PCA rate (number of PCAs).	3.8% (20)	6.1%	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)	91.7%	92.3%	91.8%	No statistical variation

PCA rate (number of PCAs).	3.4% (3)	3.6%	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>	57.4%	73.9%	75.9%	Variation (negative)
PCA rate (number of PCAs).	5.3% (9)	12.2%	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

On the day of inspection staff demonstrated an awareness of QoF data and performance as well as reasons for any decline in the effectiveness of the management of patients diagnosed with a long-term condition. Staff told us these factors included staffing constraints, the impact of the COVID-19 pandemic, a hesitance from some patients to attend the practice, and the suspension of some services during the pandemic.

Staff told us that systems were in place to review QoF data daily in order to allow an opportunistic review of patients attending appointments; performance against these indicators had been discussed at monthly clinical meetings.

Since the last inspection we saw evidence of a recall system in place for diabetic patients for non attenders; information to support patients with diabetes management; and the provider had identified additional staff to visit patients at home patients for those unable to attend the practice. A member of staff had undertaken further studies to assist in the management of patient with long term conditions. We saw evidence of an audit and actions in place to monitor the coding and recall of patients with gestational diabetes.

We saw evidence that the practice had participated in local and national initiatives to detect patient with undiagnosed conditions and had communicated with the practice population through various communications channels to raise awareness.

**Findings**

- The practice has not met the minimum 90% for two of 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
- 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.
- 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.
- We saw evidence of information available to staff to support referrals to relevant professionals.

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)	41	43	95.3%	Met 95% WHO based target
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)	40	45	88.9%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	41	45	91.1%	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)	40	45	88.9%	Below 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)	35	37	94.6%	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

Since the last inspection the provider had improved their performance across all the childhood immunisations indicators.

Clinical staff demonstrated awareness of the childhood immunisation data and explained that the provider continued offering immunisations during the COVID-19 pandemic; staff contacted the parents or guardians of children due to have childhood immunisations or whom immunisations were overdue.

We saw evidence that the provider had a system in place to work in conjunction with a third party provider to monitor immunisation take up.

The practice had a process in place to review a child's immunisation status during routine appointments.

## Working age people (including those recently retired and students)

Population group rating: Good

### Findings

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

Cancer Indicators	Practice	CCG average	England average	England comparison
(Snapshot date: ) (Public Health England)		N/A	80% Target	-
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	79.4%	72.3%	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)	65.0%	62.7%	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)	93.3%	91.0%	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)	41.9%	49.3%	54.2%	No statistical variation

### Any additional evidence or comments

At this inspection, data was unavailable for 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).

We saw evidence of published Public Health England data (Snapshot date: 30/09/2020) not verified by CQC which demonstrated the practice had met above the 80% target at 80.7% for both age groups combined, with a breakdown of 83.1% for women aged 25-49 and 77.3% for women aged 50-64.

Staff we spoke to were aware of current performance data and had a system in place to monitor uptake.



The provider had acknowledged that there had been difficulties in the uptake of cervical cancer screening during the COVID-19 pandemic and had continued to provide access to the service in line with NHS England and CCG guidance. We were assured by the provider that there would be a continued focus on this population group and the practice had an action plan in place for future planning.

The practice offered early and late appointments and dedicated staff had been identified to target non-attenders. We saw evidence of a targeted cancer screening promotion to patients.

**People whose circumstances make them vulnerable**

**Population group rating: Good**

**Findings**

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.

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

**Population group rating: Good**

**Findings**

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term 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. We saw evidence on the day of posters supporting the referral process.

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>	93.5%	85.7%	85.4%	No statistical variation
PCA* rate (number of PCAs).	6.1% (2)	18.1%	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>	75.0%	78.1%	81.4%	No statistical variation
PCA rate (number of PCAs).	4.0% (1)	8.2%	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
The practice provided care and treatment to patients with complex mental health needs who resided in a local setting. We spoke with a representative of the organisation who explained that the practice accommodated patients' needs by providing regular ward rounds or making appointments when there were no other patients at the practice, to promote safety and effectiveness of treatment. They told us that patients had received effective reviews and supportive care throughout 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)	504.1	533.9
Overall QOF score (as a percentage of maximum)	90.2%	95.5%
Overall QOF PCA reporting (all domains)	2.8%	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.	Partial
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

- We saw evidence of a second cycle audit in the safe prescribing of a medicine previously identified as having a potential risk to selective population groups. The second cycle audit demonstrated improvement.
- We saw evidence of an audit and actions in place to monitor the coding and recall of patients with gestational diabetes.

#### **Any additional evidence or comments**

At our last inspection we found:

The practice was not running regular searches or audits to identify patients who may be at risk due to medicines that they were prescribed or due to patient safety alerts that had been raised. Whilst QoF performance overall was better than average, on the day of our inspection, no-one was able to extract QoF information to obtain a current picture of performance and identify where improvements had been made.

At this inspection we found:

We saw evidence of a range of safety improvement audits completed throughout the year, however some audits occasionally lacked evidence of identified improvements.

## 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.	Partial
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.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection:</p> <ul style="list-style-type: none"> <li>• There were a number of omissions in the practice's training matrix for non-clinical staff. These included safeguarding children and adults, infection control, equality and diversity, fire and basic life support. Whereas clinicians had received safeguarding training to a relevant level, there continued to be omissions in relation to other training.</li> <li>• Not all staff had received an appraisal, some for a number of years. We looked at two appraisal records. These were pre-appraisal documents and did not evidence a discussion with the employee's line manager. However, despite this, staff told us that they felt supported and were confident to raise issues with the partners or management team. They told us that they had attended practice meetings in the past and there was one scheduled to take place later in the week.</li> <li>• After our inspection, the practice sent us information detailing how they were planning on making immediate improvements. This included a detailed training plan which included each member of staff and when they were to receive protected learning time to complete their training. The practice had updated their documentation to support the appraisal process.</li> </ul> <p>At this inspection we saw:</p> <ul style="list-style-type: none"> <li>• Evidence of a staff training matrix containing training essential to individuals' roles, including safeguarding training, infection control, equality and diversity fire &amp; basic life support. The practice had implemented a new system to monitor staff training. All staff had access to their own training record.</li> <li>• Some staff were given insufficient time to complete learning and development within their contracted hours. We heard that in some cases staff would undertake learning in their own time.</li> </ul>	

However, all staff had completed mandatory training and development needs had been discussed in appraisals.

### 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-centered care when they moved between services.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Since the last inspection, the practice had access to additional roles through the Primary Care Network, these included a clinical pharmacist, community mental health nurse, emergency contact practitioner, social prescriber and musculoskeletal practitioner.</p>	

## 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"><li>We saw evidence of signposting patients to services to support the management of their own health.</li></ul>	

### Any additional evidence or comments

## 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Remote searches carried out by the inspection team showed that Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. However, records we reviewed did not always evidence conversations and decisions made. On the day of the inspection staff had reviewed the DNACPR decisions identified within the remote searches.</li><li>• The practice provided care and treatment to patients with complex mental health needs who resided in a local setting. We spoke with a representative of the organisation who confirmed that the practice had assisted in DNACPR support and had attended multi-disciplinary meetings during the pandemic.</li></ul>	



## Well-led

**Rating: Good**

The practice is rated good for providing well-led services. This is because the provider had continued to build on improvements and governance systems and leaders were able to demonstrate a comprehensive oversight of performance and the practice had identified systems that required strengthening to ensure identified risk, actions and opportunities for learning we managed more effectively.

### 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: At our last inspection: <ul style="list-style-type: none"><li>Lower performance was identified by inspectors in respect of cervical screening. The practice was unaware of how to undertake searches of computer systems to give an up to date picture of performance and risk. Consequently, leaders did not demonstrate that they understood the challenges that the practice was facing.</li></ul> At this inspection: <ul style="list-style-type: none"><li>We saw evidence of cancer screening data, not verified by CQC, which demonstrated the practice had met both national and local targets for age groups combined. The provider had worked with the local PCN to provide additional appointment out of hours and at weekends to improve uptake. The provider had used a range of communication channels to engage and reminder patients of the importance of screening.</li><li>Leaders demonstrated an understanding of the challenges faced by the practice these included recruitment of non clinical staff. The provider had worked with external companies to assist in the recruitment process.</li><li>The provider told us that they had faced challenges during the COVID-19 pandemic, including a hesitance from patients to receive treatment and reviews; increased prescribing as a direct impact from secondary care. The practice had remained open throughout the pandemic and had proactively communicated with patients to encourage the management of health care conditions and reviews. Patients had been encouraged to purchase their own blood pressure machines.</li></ul>	

## 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
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found:</p> <ul style="list-style-type: none"> <li>• The practice displayed their aims and objectives around the practice. In these, the practice advocated safe, high quality services and commitment to ensuring that staff had the right skills to carry out their job.</li> <li>• On the day of our inspection, the practice was unable to evidence that they had effective systems and processes to meet their objective to deliver high quality services and associated regulatory requirements as they were unable to conduct searches of patients who may be at risk, nor were they able to effectively extract current QoF data to evidence continued performance.</li> <li>• A number of omissions were identified in respect of the training that had been completed by staff and therefore, the practice was unable to assure themselves that staff had the right skills for the job.</li> <li>• After the inspection, the practice took immediate action with a view to ensuring compliance with their aims and objectives.</li> </ul> <p>At this inspection we found:</p> <ul style="list-style-type: none"> <li>• Staff we spoke to knew and understood the vision, values and strategy and their role in achieving this. On the day of the inspection we saw evidence of the vision displayed around the practice.</li> <li>• We saw evidence of an awareness of QoF data and performance as well as reasons for any decline in the effectiveness of the management of patients. Staff told us that systems were in place to review QoF data daily in order to allow an opportunistic review of patients attending appointments; performance against these indicators had been discussed at monthly clinical meetings.</li> <li>• We saw evidence of a staff training matrix containing training essential to individuals' roles. The practice had implemented a new system to monitor staff training. All staff had access to their own training record.</li> </ul>	

## Culture

### The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	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.	Partial
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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>On the day of inspection we saw evidence that the practice learned and made improvements when things went wrong, however we found that the practice's incident reporting form and mechanisms for feedback did not wholly support the recording of a duty of candour notification and actions were not always monitored in a consistent way. Following our inspection, the practice submitted additional evidence to support the encouragement of a culture of candour, openness and honesty.</li> <li>We saw evidence that all staff had undertaken equality and diversity training.</li> </ul>	

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

Source	Feedback
Staff	Staff told us they felt supported by the practice. Staff felt able to raise concerns as well as make suggestions. Staff described the team as hard working, flexible and explained that during the COVID-19 pandemic staff had adapted to rapid changes to guidance positively and had remained open to patients throughout the pandemic.

## 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:	
<p>At our last inspection we found:</p> <ul style="list-style-type: none"> <li>Governance systems had not been reviewed effectively to ensure that leaders had a comprehensive oversight of performance.</li> </ul> <p>At this inspection we found:</p> <ul style="list-style-type: none"> <li>We found that the provider had continued to build on improvements and governance systems and leaders were able to demonstrate a comprehensive oversight of performance, however we found that systems required strengthening to ensure identified risk, actions and opportunities for learning we managed more effectively.</li> <li>There were designated leads for areas such as safeguarding, infection prevention and control and long-term conditions.</li> <li>Staff we spoke to told us they felt able to speak to the leaders. They told us leaders were approachable and supportive during a difficult period in delivering health services.</li> </ul>	

## 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.	Partial
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:	
<p>At our last inspection we found:</p>	

- There was not a systematic approach to identifying, managing and mitigating risks. This was partially due to the inability of the practice to utilise computer systems effectively to identify patients who may be at risk. For example, whilst we found that patients prescribed medicines that were high risk were receiving appropriate monitoring, no regular search was undertaken to ensure that processes were effective.
- This lack of effective systems extended to patient safety and medicines alerts. The practice maintained a handwritten spreadsheet of MHRA alerts and the clinician was then required to initial this spreadsheet once they had received the alert; however, there were four clinicians regularly working at the practice but often, there was only one or two signatures, indicating that this had not been read by all clinicians.
- A number of relevant patient safety and medicines alerts were raised in February and March 2019 although none of these had been recorded and actioned by the practice.
- During our inspection, we did not identify specific patients at risk. This was because the practice knew their patients well, access was good as was continuity of care; however, systems were not in place to assure leaders that all actions had been taken to mitigate risks.
- After the inspection, the practice informed us that they were in the process of developing a more systematic recall approach to identify relevant patients. Further, they sent us a spreadsheet which recorded each patient safety and medicines alert, whether a patient search was required and what follow up action was taken.
- In respect of the business continuity plan, the practice maintained a list of suppliers, contractors, stakeholders and their contact details; however, this did not include a narrative to explain what action should be taken should a major incident occur.

At this inspection we found:

- We found that the provider had continued to build on improvements and governance systems, however we found that systems required strengthening to ensure identified risk, actions and opportunities for learning we managed more effectively.
- The provider had implemented a new safety alert process. The provider told us the process had been managed centrally and audits and actions had been completed; and we saw evidence that alerts had been discussed at staff meetings.
- The provider had implemented their business continuity plan following a significant event at the practice. We saw evidence that staff had sustained continuity of care for patients and had remained open throughout the major incident and had been supported by the local clinical commissioning group.

### **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.	N/A
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Staff told us patients that were potentially digitally excluded were able to contact the practice via telephone and were assessed by a clinical member of staff, and face to face appointments were available when clinically appropriate.</li> <li>We saw evidence of compliance with the government's guidance on managing the risk of COVID-19, certified by the local clinical commissioning group (CCG) in November 2020.</li> </ul>	

### 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.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection we found:</p> <ul style="list-style-type: none"> <li>The practice was accessible and communicated openly with their practice population, who regarded them highly; however, this meant that the practice relied on individual communication rather than systems to monitor performance. Whilst this was often effective as evidenced by QOF performance and GP Patient Survey data, this could not be relied upon to ensure information was accurate, valid, reliable and timely.</li> <li>Performance information could not be obtained and therefore could not be used to hold management to account.</li> </ul> <p>At this inspection we found:</p> <ul style="list-style-type: none"> <li>The leadership team undertook reviews of practice performance against Quality Outcomes Framework (QOF), a target driven programme of quality improvement. We saw evidence that staff had access to performance information and this information was being used to target improvements.</li> <li>Regular clinical and staff meetings were held to discuss improvements in performance.</li> </ul>	

- We found that the provider had continued to build on improvements and governance systems, however we found that systems required strengthening to ensure identified risk, actions and opportunities for learning we managed more effectively.

## 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:	
Staff we spoke to were aware of relevant information governance, data protection and confidentiality procedures.	
On the day of inspection, we saw evidence that the provider had registered as a data controller with the Information Commissioner's Office.	

## 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:	
We saw evidence that the practice actively engaged with the public through a local community magazine.	
At the time of the inspection the practice did not have an active Patient Participation Group, this was due to unforeseen circumstances. The practice continued to actively advertise the role of the PPG in the practice and on the practice website.	

Feedback from Patient Participation Group.

Feedback
At the time of the inspection we were unable to receive feedback from the Patient Participation Group.

Any additional evidence

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
At the last inspection we found:	
<ul style="list-style-type: none"> <li>The practice did not have effective systems for identifying risk, learning and improvement were not always possible.</li> </ul>	
At this inspection we found:	



- Due to demand on the service and staffing constraints protected time was not always available in work time to undertake personal development.

### **Examples of continuous learning and improvement**

- The practice had been actively involved in the primary care networks and had continued to offer a range of clinicians to the practice population throughout the COVID-19 pandemic.

## 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 practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

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

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

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

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

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

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

## Glossary of terms used in the data.

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