

Care Quality Commission

Inspection Evidence Table

The London Road Medical Centre (1-5868981543)

Inspection date: 10 December 2021

Date of data download: 22 November 2021

Overall rating: Requires Improvement

At our previous inspection in April 2019 the practice was rated as Requires Improvement overall and for providing safe and well-led services. It was rated as Good for providing effective, caring and responsive services.

At this inspection, the practice is rated as Requires Improvement overall because:

- The systems and processes to ensure care and treatment was safe, were not always effective or being consistently applied. In particular: infection prevention and control, managing and mitigating risks, safe and appropriate use of medicines; and learning and making improvements when things went wrong.
- People were at risk of not receiving effective care or treatment. There was a lack of consistency in the effectiveness of the care, treatment and support that people received due to high turnover of clinicians working at the practice.
- The leadership, governance and culture did not always support the delivery of high-quality person-centred care.
- Governance processes were not always effective and being consistently applied. For example, to mitigate risk, to promote learning, continuous improvement and innovation.

Safe

Rating: Requires Improvement

At our last inspection in April 2019, the practice was rated as Requires Improvement because:

- The practice did not have clear and effective processes for managing risks.
- The practice had not fully embedded a system for reviewing results in a timely way.
- Although the practice was actively trying to recruit, they did not have sufficient numbers of clinical staff employed to meet the care and treatment needs of their registered patients.

At this inspection the practice remained rated as Requires Improvement for providing safe services, because:

- Systems to assess, monitor and manage risks to patient safety were not always effective.
- Staff did not always have the information they needed to deliver safe care and treatment.
- There were gaps in systems to ensure medicines prescribed were used appropriately reviewed in line with current best practice guidance.
- They did not have sufficient numbers of clinical staff employed to meet the care and treatment needs of their registered patients, which remained a systemic issue.

- The system used to make improvements when things went wrong was not consistently applied.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
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
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
<p>Explanation of any answers and additional evidence:</p> <p>We saw the practices safeguarding children and adult's policy, which was dated as last reviewed in March 2019. The policy had not been reviewed since this time and detailed GP partners who were no longer working at the practice.</p> <p>Staff we spoke to were clear of their roles and responsibilities in relation to safeguarding identification, recording, and how to report any concerns to the GP or practice nurse.</p> <p>Records of staff training, confirmed that all staff had received the appropriate level of training in safeguarding adults and children.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	N
<p>Explanation of any answers and additional evidence:</p> <p>We looked at the personnel records of five members of staff. These records showed that Disclosure and Barring Service (DBS) checks were undertaken when required. From these found we found that required documentation had not always been obtained. For example, proof of identity, terms and conditions of employment (contracts), references and proof of registration with other registered bodies. We asked to see the Hepatitis B vaccination records of two members of clinical staff and the provider was unable to show that these had been obtained nor that they were being maintained in line with Public Health England (PHE) guidance.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: December 2021	Y
There was a fire procedure. Date of fire risk assessment: November 2021	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>During our inspection visit, we were unable to establish that the practice had a Legionella risk assessment and action plan. (Legionella is a bacterium found in water supplies which can cause severe respiratory illness).</p> <p>We saw from records checked that Portable Appliance Testing (PAT) and Calibration test certification had been completed in January 2021 and October 2021.</p> <p>We found control of substances hazardous to health (COSHH) and cleaning products kept in a locked room. However, the lock was not sufficient to prevent unauthorised persons gaining access. Following the inspection, we received an email from the registered provider, to show that a more appropriate lock had been fitted.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not always met.

	Y/N/Partial
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: April 2020	Partial
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection on 23 April 2019, we saw an infection prevention and control (IPC) audit was carried out in February 2019. Actions were identified as a result of this audit. For example, some flooring had split and required replacement. Quotes for the work to replace the flooring had been received by the practice, with the work to be completed in May or June 2019. At this inspection, we saw that these works had been completed.</p> <p>The systems and processes for IPC were not always effective, nor were they in line with current guidance. We saw that the last IPC audit had been completed in April 2020, no further audit had been undertaken since. We saw that the infection prevention and control policy was dated April 2016 and no reviews had been completed or amendments made since this time. Following the inspection, we were sent a copy of the IPC COVID policy which was dated December 2021. This included details of additional IPC precautions but did not include any other IPC data. For example, spills and blood borne viruses, use of personal, protective equipment and handwashing.</p>	

In consultation rooms, we saw that disposable, paper curtains had not been dated and there was no system for the routine changing of these.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
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> <p>The practice had a list of 7323 patients and one full time GP (the registered provider/single handed principal GP). This is compared to 4084 at CCG level and 1767 at national level (per full time GP). The provider had been actively trying to recruit further GPs and/or clinicians. However, we were told that advertising for these roles had recently ceased but were due to be recommenced again in January 2022. The practice relied on the use of locum of GPs and nursing staff to ensure clinical staffing numbers were appropriate to the number of patients registered. However, this meant that there had been a high turnover in numbers of clinicians working at the practice and there were periods of time during August 2021, where the single-handed principal GP was the only GP working at the practice.</p> <p>The non-clinical staff team were multi-skilled and could cover for one another for periods of holiday or sickness.</p> <p>During our inspection visit, we saw a policy and procedure for responding to medical emergencies. Staff were aware of actions to take if they encountered a deteriorating or an unwell patient. We spoke to staff about training they had received, and they told us they had received training in sepsis and had been provided with information about this subject matter. We saw posters and guidance documents available in the practice to support raising staff awareness.</p>	

Information to deliver safe care and treatment

Staff did not always act on the information they had 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.	Partial
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw that there were 1300 documents on Docman (a cloud-based platform for managing clinical content). We were told by the single-handed principal GP they had an issue with coding and with scanning letters on to the system, which had been resolved. We were told that these documents had been actioned and were duplicated documents. We reviewed these and found that 394 required filing (dating back to 2 December 2021) and confirmed this to be the case. The practice had the support of the CCG medicines optimisation team and were trying clear the backlog.</p> <p>We discussed pathology (blood test) results with the single-handed principal GP and found there were 87 results waiting which had not been actioned between 2 to 10 December 2021. Were told that the single-handed principal GP had a plan to address these with the support of one of the locum GPs. Backlogs of these had been identified as a systemic issue and an alternative plan was being drafted. For example, delegating the practice nurse to review diabetes results and the health care assistant to review the blood results, following the NHS Health check protocol. Both clinicians would then refer abnormal results to the single-handed principal GP. However, we found that the single-handed principal GP was managing these, and the plan had not been implemented.</p>	

Appropriate and safe use of medicines

The practice did not always have 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)	0.78	0.73	0.69	-
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)	12.6%	10.6%	10.0%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r	8.01	5.89	5.38	Significant Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2021 to 30/06/2021) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	197.5‰	129.7‰	126.1‰	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)	0.58	0.67	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	7.6‰	6.7‰	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
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
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.	Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y

Medicines management	Y/N/Partial
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
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.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial
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> <p>We found that the routine checking of emergency use oxygen, the nebuliser machine and AED, had ceased following a member of clinical staff leaving the practice.</p> <p>We saw that emergency use oxygen and a nebuliser machine (a machine which turns liquid medicine into a fine mist for inhalation) had been routinely checked throughout 2019. However, there were no records beyond this date either in paper or computerised format.</p> <p>There was an Automated Emergency Defibrillator (AED) on site, which had been checked routinely until September 2020. However, no further records of checks were being maintained since this date, either in paper or computerised format.</p> <p>We saw there was a policy and guidelines for the treatment of anaphylaxis (severe allergic reaction). However, this was dated as reviewed in April 2019. We looked but could not find any further reviews having taken place or of the policy having been updated if needed.</p> <p>There were appropriate emergency medicines and risk assessments to determine the range of medicines held. There was a system to monitor stock levels and expiry dates (we checked this and found this to be the case). However, these were not being maintained routinely to monitor usage or replace stock if needed.</p> <p>At our previous inspection in April 2019, data showed that the practice prescribed more than average certain antibiotics, compared to England and local average. For example, at this time the practice scored an indicator of 7.26 for the prescribing of antibiotics; Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim.</p> <p>During this inspection, data showed the practice indicator score had increased to 8.01, the single handed principal GP told us that the practice was receiving support from the clinical pharmacist with the Sittingbourne primary care network (PCN) to help address this and decrease the number of antibiotics being prescribed.</p> <p>We were told by the single-handed principal GP that they had established recall system for reviews of patients prescribed high-risk medicines and that these were resumed as face to face appointments. However, we were also told that from September/October 2021 the practice had suspended these while focussing on Influenza immunisations.</p> <p>We looked at the records of patients prescribed spironolactone (five records), methotrexate (four records), carbimazole valproate (five records) or lithium (four records). We found that not all these</p>	

Medicines management	Y/N/Partial
<p>patients' records showed that best practice guidance for the management of these high-risk medicines had been followed. For example;</p> <ul style="list-style-type: none"> • For patients prescribed spironolactone - a medicine prescribed to reduce fluid overload and reducing the amount of work the heart has to do to pump blood around the body, we found that three had not had blood tests undertaken within the required timescale of every six months. One was last tested in July 2019 and two were in January 2021. We also found that one patients record had not been coded correctly, to ensure all clinicians were aware of the patient's history of skin cancer. We saw one patient that had not been tested since 2019, had also not been recorded on the system as having been diagnosed with chronic kidney disease stage two, when previously diagnosed as stage two. • For female patients of childbearing age, prescribed carbimazole valproate, we found that for two their medical records indicated they provided with information relating to contraception and the risks of taking of this medicine during pregnancy. • For patients prescribed lithium, we found two had not had their blood calcium levels checked within the required timescale of once per year. One was last checked in May 2019 and the other May 2020. We also found one patient who had not had their lithium levels checked within the required timescale of every three months. The last check recorded in their noted was April 2021. However, the single-handed principal GP and staff were aware of this patient and had made attempts to contact them. <p>All patients prescribed methotrexate had been monitored appropriately and in line with best practice guidance.</p>	

Track record on safety and lessons learned and improvements made

The practice did not have an effective system to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	N
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.	N
Number of events recorded in last 12 months:	
Number of events that required action:	0
<p>Explanation of any answers and additional evidence:</p> <p>We asked to see records of significant event reporting. There was a spreadsheet in use which showed one event recorded in early 2020 (which was the only recorded event in the last 23 months). This had been investigated and appropriate action taken. We also found an event elsewhere on the practices computer system dated January 2020, which had been investigated. However, there was no recording of learning outcomes having been shared with staff. We spoke with staff who gave a mixed understanding of how to report these. Some staff aware that there was a form to submit to either the single-handed principal GP or practice management team. Some stating there wasn't a form and they</p>	

would speak with the practice manager. Therefore, there was an inconsistent approach to reporting and systems and processes were not being used effectively.

Example of significant events recorded and actions by the practice.

Event	Specific action taken
Potential risk of a needlestick injury.	Following a flu vaccine clinic, an unsheathed needle for injection had been found by the cleaner on a table in a consultation room. The single-handed principal GP was informed, and all necessary actions were taken to discard of the needle appropriately. Following the incident, a memo had been sent to clinicians to remind them of the importance of disposing of clinical waste in the appropriate sharp's bins.

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
<p>Explanation of any answers and additional evidence:</p> <p>We saw that there was a system for monitoring and recording alerts received from the Medicines and Healthcare products Regulatory Authority (MHRA). However, we saw that these systems were not always being consistently applied. For example, for female patients of childbearing age, prescribed carbimazole valproate.</p>	

Effective

Rating: Requires Improvement

At our last inspection in April 2019, the practice was rated as Good for providing effective services.

At this inspection the practice was rated as Requires Improvement because:

- Records showed that reviews of patients with long-term conditions were not always completed in line with current best practice guidance.
- Although the pandemic had had a detrimental effect on the practice's ability to deliver some care as well as treatment, performance relating to child immunisations and cervical screening still required improvement.
- Not all staff had access to regular appraisals.
- The practice obtained consent to care and treatment in line with legislation and guidance.

QOF requirements were modified by NHS England for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

Effective needs assessment, care and treatment

Patients' needs were not always assessed, and care and treatment, 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.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Partial
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y

Explanation of any answers and additional evidence:

We looked at five records each for patients diagnosed as pre-diabetes and patients diagnosed with asthma and prescribed inhalers. We found that not all patients' records showed best practice guidance for the management of these had been followed. For example,

- In two records for patients with pre-diabetes, we found their records were not coded correctly and neither of the patients has been informed they were diagnosed as such. One had been tested in May 2021 and the other in September 2021.
- In the records for patients with asthma using an excessive number of short acting inhalers we looked at five out of the 11 identified patients. We found that all five had not received an appropriate review within the required timescale of every year.

Effective care for the practice population

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.
- 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.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- All patients with a learning disability were offered an annual health check. Those accommodated in one of four local care homes, were reviewed and consulted as part of weekly ward rounds.
- 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.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.

- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Adults with newly diagnosed cardio-vascular disease were offered statins.

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)	70	77	90.9%	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)	63	69	91.3%	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)	63	69	91.3%	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)	62	69	89.9%	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)	62	73	84.9%	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

The practice was aware of their target rate for childhood immunisations. We were told by the single-handed principal GP that due to the absence of the practice nurse they had employed a long-term locum practice nurse in November 2021, who had helped with addressing the backlog and managing immunisations.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2021) (Public Health England)	75.7%	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)	72.0%	70.6%	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)	69.8%	64.3%	63.8%	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)	47.9%	55.3%	54.2%	No statistical variation

Any additional evidence or comments

The practice was aware of their target rate for cervical screening. We were told by the single-handed principal GP that due to the absence of the practice nurse; cervical screening was placed on hold in October 2021. Since this date, the single-handed principal GP had employed a long-term locum practice nurse in November 2021, who had helped with completing cervical screening and addressing the backlog.

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.

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

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

We saw an audit in relation to monitoring of patients who fitted the criteria of National Council on Disability Affairs – lung cancer peer to peer review. The audit showed that relevant patients were reviewed, and actions were taken, as necessary, to refer to either secondary or support services.

Any additional evidence or comments

From records viewed we saw that audits were in progress in relation to a blood thinning medicine, as well as one for medicines used in the treatment of arthritis.

Effective staffing

The practice was unable to fully demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	N
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice. For example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

From staff files that we viewed; we saw that no appraisals had been completed for a period of two years. The practice management team and single-handed principal GP were aware of this. We were told by the practice manager that there was a plan to address this in November 2021. However, they had not been carried out as planned. As a result, the practice management team were reviewing how to complete these using remote calls to staff. They had set a target date of January 2022 for all appraisals to be carried out.

Coordinating care and treatment

Staff did not always work 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.	Partial
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
<p>Explanation of any answers and additional evidence:</p> <p>In the five records for patients with asthma using an excessive number of short acting inhalers we found in one set of records, a review had been requested by a secondary care service in September 2020, but this had not been followed up.</p> <p>Themes identified from complaints received by the practice and via the CQC website, showed that referrals were not always made within appropriate timescales.</p>	

Helping patients to live healthier lives

Staff were 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

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

Caring

Rating: Good

At our last inspection in April 2019, the practice was rated as Good for providing Caring services and remained rated as Good at this inspection.

Kindness, respect and compassion

Feedback from patients was mixed about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

Reviews left on the NHS Choices website	
Total reviews	5
Number of reviews that were positive about the service	0
Number of reviews that were mixed about the service	0
Number of reviews that were negative about the service	5

Experience shared with CQC directly via our website	
Total received	4
Number received which were positive about the service	0
Number received which were mixed about the service	0
Number which were negative about the service	4

Examples of feedback received	Source
<ul style="list-style-type: none">Feedback about the practice captured in the national GP patient survey (results published in July 2021) was mixed.The reviews left on the NHS Choices website and experience shared with CQC directly via our website about services at The London Road Medical Centre were negative.The main theme from negative feedback we received from patients was that they found it difficult when contacting the practice by telephone, found it difficult to book an appointment, difficulties with timely referrals and felt that staff were abrupt and unhelpful.	Reviews left on the NHS Choices website and experience shared with CQC directly via our website.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	81.3%	87.9%	89.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)	79.1%	87.0%	88.4%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	93.8%	95.2%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	65.0%	79.8%	83.0%	Variation (negative)

Any additional evidence or comments

At our previous inspection in April 2019, the national GP patient survey data was prior to the provider being registered at the practice and was therefore not applicable.

We looked but did not see any evidence that low survey results were discussed, nor actions being considered to address these.

Question

The practice carries out its own patient survey/patient feedback exercises.

Y/N

N

Any additional evidence

The patient participation group (PPG) told us that surveys were being considered prior to the pandemic. However, this had been placed on hold until more members could be recruited and meetings to discuss possible surveys could be resumed.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: Easy read and pictorial materials were available.	

Source	Feedback
Interviews with patients.	We spoke with two patients, who told us that the single-handed principal GP and locum GPs were very good at spending time explaining and discussing care and treatment options with them.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	95.4%	92.9%	92.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 331 patients who were carers (4% of the practice list).
How the practice supported carers (including young carers).	There was a dedicated section on the practice's website that indicated support available to carers and encouraged patients to identify whether they were carers. The practice offered carers an annual influenza vaccination and an annual health check.
How the practice supported recently bereaved patients.	All bereavements were notified to all staff, so they were aware when talking to relatives. We received mixed feedback from staff as to whether the patients' GP called the family and offered a consultation. The practice also provided help by signposting relatives to other support services where appropriate.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence: We saw posters in the waiting room and reception area, informing patients that they could ask to speak with staff confidentially. Minutes of meetings also included notes of discussions held, reminding staff about the importance of maintaining patient confidentiality at the reception desk.	

Responsive

Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Partial
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had one full time GP (the registered provider/ single handed principal GP), despite a number of recruitment drives to employ permanent clinicians, and relied on the use of locum of GPs and nursing staff,. This meant that there had been a high turnover in numbers of clinicians working at the practice. Staff we spoke with told us that this resulted in a high number of verbal complaints, about the consistency of care they received. However, the practice did not keep records of verbal complaints so that these could be analysed.</p>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Appointments available:	
Monday	8.30am to 11.30am & 2.30pm to 5.30pm
Tuesday	8.30am to 11.30am & 2.30pm to 5.30pm
Wednesday	8.30am to 11.30am & 2.30pm to 5.30pm
Thursday	8.30am to 11.30am & 2.30pm to 5.30pm
Friday	8.30am to 11.30am & 2.30pm to 5.30pm

Further information about how the practice is responding to the needs of their population

- All patients were registered with the single-handed GP in the practice who ensured they were supported in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

People were not always able to access care and treatment in a timely way.

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	Y/N/Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Patients were able to make appointments in a way which met their needs.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
There were systems in place to support patients who face communication barriers to access treatment.	Y
Patients with urgent needs had their care prioritised.	Y
The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.	Y
Explanation of any answers and additional evidence:	

The practice continued to operate throughout the pandemic providing a range of appointments, including; face to face, video and telephone consultations, as well as home visits. Online services had also been implemented.

Access issues identified predominantly related to clinical staffing numbers. At times during the pandemic there had only been the single-handed principal GP working. However, long-term locums were being employed and the single-handed principal GP was liaising with the CCG to address shortfalls and increase clinical staffing numbers by means of recruitment of permanent GPs, which had proved challenging in the local area.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	47.2%	N/A	67.6%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	55.8%	66.3%	70.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	44.9%	62.8%	67.0%	Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	77.3%	80.5%	81.7%	No statistical variation

Any additional evidence or comments

At our previous inspection in April 2019, the national GP survey data was prior to the provider being registered at the practice and was therefore not applicable.

In April 2019, the practice had modernised its telephone system. There was now a call queue which could hold between 12-15 calls and an automated message was conveyed to those waiting.

The 2021 GP patient survey results show that the practice performed below the local and England average in relation to the ease of getting through on the phone and satisfaction with appointment times. The practice told us that in 2019 they had modernised the telephone system. However, there was no evidence that the survey results had been discussed or actions considered to improve these, nor that monitoring of the new phone system had identified improvements regarding access.

Source	Feedback
NHS Choices	We reviewed comments logged on the NHS Choices website. There were five comments registered. All comments were negative in relation to access. All the reviews had been acknowledged by the practice and responded to.

Listening and learning from concerns and complaints

Complaints were listened and responded to but not always used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	17
Number of complaints we examined.	5
Number of complaints we examined that were satisfactorily handled in a timely way.	5
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: The system for managing and responding to complaints was effective. However, staff told us they received several verbal complaints, but there was no system for documenting this. We found that theme and trends had been identified from the complaints received. For example, staff attitude, prescription errors and timely referrals to other services.	

Example of learning from complaints.

Complaint	Specific action taken
A patient complained about being unhappy with the delay in a referral to another service.	The practice acknowledged the complaint, spoke with the patient and reviewed the processes undertaken for sending referrals to other service providers. As a result, referral policies and processes were updated.

Well-led

Rating: Requires Improvement

At our last inspection in April 2019, the practice was rated as Requires Improvement because:

- The overall governance arrangements were not consistently effective.

At this inspection the practice remained rated as Requires Improvement for providing safe services, because:

- Leaders could not always demonstrate that they had the capacity and skills to deliver high quality sustainable care.
- The practice did not always have a clear vision or credible strategy to provide high quality sustainable care.
- The overall governance arrangements were not effective.
- The practice did not always have clear and effective processes for managing risks, issues and performance.
- There was little evidence of systems and processes for learning, continuous improvement and innovation.

Leadership capacity and capability

Leaders could not always 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.	Partial
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence: Staff feedback was mixed about the single-handed principal GP being approachable. We were told by staff that they could not always be assured if they approached them, they would be open to discussing matters needing to be either raised or addressed. The single-handed principal GP had recognised that succession planning was a matter of importance, given the current staffing levels and high turnover of locum of clinicians. We were told by stakeholders prior to the inspection, that discussions were being held to help support the reduction of the patient list size and a possible merger between The London Road Medical Centre and another local practice. The single-handed principal GP confirmed this when we spoke with them during the inspection. However, this was in discussion stage and no clear plan or programme had been established.	

Vision and strategy

The practice had a clear vision, but it was not supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Staff we spoke with were aware of the visions and values of the practice. However, they were not aware of the strategy moving forward. The current staffing levels and high turnover of locum staff meant that staff were unclear about how changes would be made. They told us that with the principal GP being the lead for all matters, there were no delegated roles and as such, strategies were not being discussed as effectively as they could be.</p>	

Culture

The practice culture did not always effectively support 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.	N
There was a strong emphasis on the safety and well-being of staff.	Partial
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 had access to a Freedom to Speak Up Guardian.	N
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was a clear disconnect between the single-handed principal GP, practice management team and administrative staff, which had been recognised. The clinical commissioning group (CCG) were aware and had supported the whole practice team to drive forward and give guidance on how to resolve this. The single-handed principal GP was also receiving support from the Local Medical Council.</p> <p>We saw a duty of candour policy, which was dated October 2019 and for review in October 2020. However, this review had not been completed. Records viewed of complaints investigations, did however, show that duty of candour was being applied consistently in responses to complainants.</p>	

Staff we spoke with were not aware of who to contact if they needed to access a Freedom to Speak Up Guardian and there was no reference made to how to access one or who this was, in any of the practices policies and procedures.

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

Source	Feedback
Staff interviews	We spoke with staff who told us that the practice leader was not always approachable, they did not always feel culture of openness existed and they did not feel the practices whistle blowing policy was always followed appropriately, when they raised concerns. Staff said they found the locum GP's approachable regarding clinical matters.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection in April 2019, we found there was a system for completing and reviewing policies. However, it did not identify that some policies were specific to the practice.</p> <p>At this inspection, we found there was a lack of an effective governance framework consistently being applied. Systems and processes were not effectively embedded and operated to ensure the registered provider could assess, monitor and improve the quality and safety of the services; nor the risks relating to the health, safety and welfare of service users and others who may be at risk. For example, risks relating to; infection prevention and control, legionella, staff recruitment files and sufficient staffing numbers.</p> <p>There was a set of policies, procedures and information on site for staff to access. However, somewhere on a shared drive on the computer and some were on another software platform, which had recently been introduced. It was, therefore, difficult to ascertain which version of the policy or procedure was most current. We saw that policies had been reviewed in 2019 and were scheduled for review in 2020. However, these had not taken place. For example, policies relating to IPC, safeguarding adults and children, grievance, duty of candour and significant events.</p> <p>We reviewed the practice website and found this was not up to date in terms of staff who worked at the practice. It did, however, contain relevant information for patients on how to contact the practice, use of electronic consultations and COVID guidance, for example.</p>	

Managing risks, issues and performance

The practice did not always have effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Partial
There was a quality improvement programme in place.	N
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
<p>Explanation of any answers and additional evidence:</p> <p>We looked at what arrangements were in place to respond to emergencies and major incidents. Staff were aware of the plan and had access to this. However, the business continuity plan, which contained this information was dated October 2020 and included details of staff who no longer worked at the practice.</p> <p>We saw minutes of meetings between the single-handed principal GP and practice management team. These provided details of discussions held relating to premises, staffing and patients of concern. We also saw minutes of meetings with administrative staff. However, there was no discussions noted about issues identified or ways in which services could be improved. For example, significant events or complaint learning outcomes, as well as safeguarding concerns.</p>	

The practice did not always have systems 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.	N

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> <p>All digitally excluded patients were coded as such on their patient records and offered face to face appointments.</p> <p>The practice was aware of their need to address backlogs with childhood immunisations, cervical screening and correspondences on the computer system which required linking to patient records. A long-term locum practice nurse had been employed to address childhood immunisations and cervical screening. The single-handed principal GP had been supported to address the longer-term backlog of correspondence but had not caught up completely. This meant each day that new correspondence was received, the backlog increased again. Support had also been provided by the CCG pharmacy team, to help address this.</p>	

Appropriate and accurate information

There was no 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.	Partial
Performance information was used to hold staff and management to account.	N
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice did not have an effective system to ensure that performance and improvements were monitored. For example, verbal complaints management, significant event reporting and national GP survey results.</p>	

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

Engagement with patients, the public, staff and external partners

The practice did not always involve 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.	Y
Staff views were reflected in the planning and delivery of services.	N
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> <p>The practice had an established patient participation group (PPG), which consisted of three members (a chair, a secretary and a treasurer). PPG meetings were postponed during the pandemic but were due to be recommenced. The practice/PPG were looking at ways to recruit new members as they understood that they were not representative of the patient population. They had created a newsletter in the past and were keen to reestablish this moving forward.</p> <p>Minutes of staff meetings did not always reflect matters that staff had raised as areas of concern or for improvement. For example, whistleblowing concerns raised.</p>	

Feedback from Patient Participation Group.

Feedback
<p>The PPG reported that due to the pandemic it had been a difficult period to operate effectively. They were aware they needed to raise the profile of the PPG and actively recruit new members. We were told that a PPG constitution and code of practice had been established and would be reviewed again at the next annual general meeting, planned for April 2022.</p> <p>They told us they did not, at this time, feel they were supporting the practice as effectively as they could be and would be networking with other practice PPG's to gain a better understanding of how they could do this.</p>

Continuous improvement and innovation

There was little evidence of 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.	Partial
Explanation of any answers and additional evidence: We saw that a culture of learning and innovation was sporadic and was not always present. For example, minutes of meetings did not always reflect significant events, complaints and discussions with staff in relation to improvements required. The single-handed principal GP was working collaboratively with the CCG and Local Medical Council, to ensure the support available, was being accessed.	

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.
-
- %_o = per thousand.