# Care Quality Commission

## Inspection Evidence Table

## Botley Medical Centre (1-544081039)

**Inspection date: 7 and 8 December 2021**

**Date of data download: 30 November 2021**

# Overall rating: Requires improvement

At our previous comprehensive inspection in April 2021 we found significant concerns at Botley Medical Centre and rated the practice inadequate overall. We issued urgent conditions against the provider.

At this inspection we found there had been improvements to the safety and effectiveness of services. However, there were still concerns regarding identification of quality improvement, the monitoring of care and other specific issues. We have therefore rated the practice as requires improvement.

# Safe Rating: Good

At our previous inspection in April 2021 we found staff were not inducted into their roles appropriately meaning they did not have sufficient knowledge of safety systems and processes. We found concerns regarding high risk medication monitoring and due to broader search criteria on the clinical system, identified extensive clinical risks. We found clinical records were not maintained appropriately to ensure patients were able to have their care monitored safely. Medicine safety alerts were not acted on to keep patients safe.

At this inspection there were significant improvements to safety.

**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. | Yes |
| Partners and staff were trained to appropriate levels for their role. | Yes |
| There was active and appropriate engagement in local safeguarding processes. | Yes |
| The Out of Hours service was informed of relevant safeguarding information. | Yes |

| Safeguarding | Y/N/Partial |
|---|---|
| There were systems to identify vulnerable patients on record. | Yes |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Yes |
| 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. | Yes |

| Recruitment systems | Y/N/Partial |
|---|---|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Partial |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role. | Yes |
| Explanation of any answers and additional evidence:<br><br>We found that a clinical member of staff recruited since the last inspection had an appropriate record of the immunisations. One member of staff who had been recruited since April 2021 did not have a full employment history. One member of staff had not had verification of their qualifications during their recruitment. | |

| Safety systems and records | Y/N/Partial |
|---|---|
| Health and safety risk assessments had been carried out and appropriate actions taken.<br>Date of last assessment: August 2021 | Yes |
| There was a fire procedure. | Yes |
| Date of fire risk assessment: March 2021<br>Actions from fire risk assessment were identified and completed. | Yes |

**Infection prevention and control**

## Appropriate standards of cleanliness and hygiene were met.

| | Y/N/Partial |
|---|---|
| Staff had received effective training on infection prevention and control. | Yes |
| Infection prevention and control audits were carried out.<br>Date of last infection prevention and control audit: July 2021 | Yes |
| The practice had acted on any issues identified in infection prevention and control audits. | Yes |
| The arrangements for managing waste and clinical specimens kept people safe. | |

**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. | Yes |
| There was an effective induction system for temporary staff tailored to their role. | Yes |
| The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures. | Yes |
| 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. | Yes |
| There were enough staff to provide appointments and prevent staff from working excessive hours | Yes |

Explanation of any answers and additional evidence:

In April 2021 we found staff were not provided with inductions or training which included safeguarding, identification of high risk symptoms and infection control among other areas.

At this inspection staff reported receiving inductions before beginning their roles. We saw induction plans were in place and staff reported these were monitored by a practice manager. Staff had access to guidance on identifying high risk symptoms or ‘red flags’ to ensure they could priorities patients with the most urgent needs.

**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. | Yes |
| There was a system for processing information relating to new patients including the summarising of new patient notes. | Yes |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. | Yes |
| Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals. | Yes |
| There was a documented approach to the management of test results and this was managed in a timely manner. | Yes |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | Yes |

Explanation of any answers and additional evidence:

In April 2021 patient records were not monitored appropriately to ensure that clinical tasks were acted on. For example, we found instances where test results requiring actions by clinicians to ensure patient safety, were filed on patient records without any action being recorded. Shared care agreements (sometimes required when care is shared between external services and GP practices) were not always in place when needed.

At this inspection we found that there had been a significant improvement to the recording and monitoring of patient records. Clinical coding had been improved to ensure that, in nearly all records we reviewed, clinicians were prompted when patients required specific reviews or interventions. There was an instance of incorrect coding which we informed the practice of so they were able to address this.

**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) (01/10/2020 to 30/09/2021) (NHS Business Service Authority - NHSBSA) | 0.63 | 0.63 | 0.71 | 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). (01/10/2020 to 30/09/2021) (NHSBSA) | 12.0% | 12.2% | 9.8% | 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 (01/04/2021 to 30/09/2021) (NHSBSA) | 4.62 | 5.24 | 5.32 | No statistical variation |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA) | 52.9‰ | 87.2‰ | 126.1‰ | Variation (positive) |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2020 to 30/09/2021) (NHSBSA) | 0.45 | 0.41 | 0.63 | No statistical variation |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA) | 4.1‰ | 5.3‰ | 6.7‰ | Tending towards variation (positive) |

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. | Yes |
| Blank prescriptions were kept securely, and their use monitored in line with national guidance. | Yes |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Yes |

| 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. | Yes |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. | Yes |
| 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. | Yes |
| 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. | Yes |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Yes |
| There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. | Yes |
| 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. | Yes |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | Yes |
| For remote or online prescribing there were effective protocols for verifying patient identity. | Yes |
| 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. | Yes |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Yes |
| Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective. | Yes |

Explanation of any answers and additional evidence:

In April 2021 we identified that there were patient records with no up to date recording of reviews of their medication. Patients were being prescribed medicines associated with high risk side effects, without the appropriate monitoring to determine if the dosage was safe or patients were safe to continue taking their medicines.

At this inspection we found significant improvements to the monitoring of high risk medicines. Reviews of patients' prescribed medicines were taking place routinely due to improved monitoring systems and record keeping of the clinical system.

**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. | Yes |
| Staff knew how to identify and report concerns, safety incidents and near misses. | Yes |
| There was a system for recording and acting on significant events. | Yes |
| Staff understood how to raise concerns and report incidents both internally and externally. | Yes |
| There was evidence of learning and dissemination of information. | Yes |
| Number of events recorded in last 12 months: | 16 |
| Number of events that required action: | 16 |

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

| Event | Specific action taken |
|---|---|
| We reviewed minutes from a clinical meeting where significant events were discussed. | Two events included where mistakes had occurred due to information not being appropriately processed or assessed. There was discussion regarding clinicians ensuring they read information when processing care tasks. |

| Safety alerts | Y/N/Partial |
|---|---|
| There was a system for recording and acting on safety alerts. | Yes |
| Staff understood how to deal with alerts. | Yes |

Explanation of any answers and additional evidence:

In April 2021 we identified risks associated with poor recording and a lack of action regarding medication safety alerts.

At this inspection we found significant improvements to the monitoring of alerts. Patients' care was reviewed when required in response to safety alerts.

# Effective Rating: Requires improvement

*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.*

At our inspection in April 2021 we rated the practice requires improvement for providing an effective service because: Records were not maintained appropriately to ensure effective recording and management of patient care took place. There was a lack of coherent governance to ensure quality improvements were made where required and that risks to patients were identified and acted on. Training was not monitored or always undertaken by staff to ensure they had the skills and knowledge to work with patients.

At this inspection we found significant improvement to the recording and managing of patients' care. However, the practice was still not reviewing all patient care as required and was not undertaking clinical audit activity aimed at identifying areas for improvement.

**Effective needs assessment, care and treatment**

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

| | Y/N/Partial |
|---|---|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice. | Yes |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Yes |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. | Yes |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Yes |
| Patients' treatment was regularly reviewed and updated. | Yes |
| There were appropriate referral pathways to make sure that patients' needs were addressed. | Yes |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Yes |
| The practice had prioritised care for their most clinically vulnerable patients during the pandemic | Yes |

## Effective care for the practice population

| Findings |
|---|
| The practice told us they have prioritised care for the most vulnerable patients during the pandemic. During our inspection we found that the practice offered: |

- Patients had access to appropriate health assessments. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. There were regular internal and multidisciplinary meetings to discuss the care and support needs of patients and their families.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- 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. During the inspection our specialist advisor reviewed the register for patients with a mental health condition. 131 patients were recorded on the register and, of these, 23 (18%) had a care plan in place. Our specialist advisor reviewed eight records and no concerns were identified. There was evidence that regular discussions with the patients were taking place and where appropriate the care plan was shared with other organisations.
- During the inspection our specialist advisor completed searches of the practice's clinical system to review the care they were providing to patients including a search to identify any who may have a missed diagnosis of diabetes. This looks for patients with symptoms which would indicate they had diabetes without this being recorded. This would mean the patient was at risk of diabetic complications including cardiovascular events, eyesight damage, kidney damage and peripheral neuropathy without being identified for appropriate treatment or monitoring to reduce these risks. The search identified three patients. One patient had been diagnosed during the week of inspection and had an appointment to discuss this and two patients required repeat tests to confirm the diagnosis. No concerns were identified.

## Management of people with long term conditions

**Findings**

- Patients with long-term conditions were offered a structured annual review to check their health and medicine 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.
- The practice informed us a new recall system for patients with chronic conditions had been introduced recently. The process was designed to be operated by two members of staff contacting all patients who were due monitoring checks for their health condition on the first day of each month. This is a term which refers to the pre-long term condition review where weight, bloods, air flow, foot checks, can be taken prior to the consultation. The follow up appointment happened at the same time.

- Our specialist advisor completed targeted case reviews of two patients' records. They found no concerns with the management of the patients' conditions and appropriate reviews were taking place.
- We were told patients with learning disabilities were offered an annual health check and the register of these patients had been allocated to the practice's physicians associate. At the time of the inspection there were 32 patients on the learning disabilities register and, of these, 17 (53%) had received an annual health check. The practice informed us they planned to undertake the remaining health checks before the end of the year cycle (March 2022).
- We reviewed patients' clinical records and minutes of meetings between multi-disciplinary teams and found that patients on the palliative care register received frequent contact from the practice to monitor their needs. We also saw evidence of regular discussion among teams where cases were reviewed, additional support was identified and referrals were made.

| 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) | 96 | 111 | 86.5% | Below 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) | 124 | 135 | 91.9% | 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) | 125 | 135 | 92.6% | 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) | 125 | 135 | 92.6% | Met 90% minimum |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England) | 159 | 172 | 92.4% | 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 |
|---|
| • The practice's uptake for childhood immunisations (validated data published by Public Health England) was above the 90% minimum target for four out of the five measured outcomes under the national programme. However this data was for the period 01/04/2019 to 31/02/2020. During the inspection we asked for the practices' current unpublished, unverified data which is below.<br><br>• 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) was 91%<br>• The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection was 85%<br>• The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b and Meningitis C was 83%<br>• The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) was 84%<br>• The percentage of children aged 5 who have received immunization for measles, mumps and rubella (two doses of MMR) was 91%<br><br>This data showed that only two of the immunisations were above the 90% minimum target and none had achieved the World Health Organisations target of 95%.<br>We spoke with the practice about the low figures and they told us they had a high proportion of patients who live in other countries for parts of the year which made the recall process and any other attempts to encourage these patients to attend challenging. |

| 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) | 65.9% | N/A | 80% Target | Below 70% uptake |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE) | 71.7% | 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) | 65.8% | 64.4% | 63.8% | N/A |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two | 70.8% | 65.5% | 54.2% | No statistical variation |

| | | | | |
|---|---|---|---|---|
| week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE) | | | | |

## Any additional evidence or comments

The practice's uptake for cervical screening (validated data published by Public Health England regarding cervical screening rates) was 65.9%. This was below the 70% coverage target for the national screening programme. During the inspection the practice provided their current unpublished, unverified quality data and as of 2 December 2021 the figures for women who had attended appointments was:

- The percentage of women aged between 24 – 49 years old who had had a cervical screening appointment within 3.5 years was 61%.
- The percentage of women aged between 50 – 64 years old who had had a cervical screening appointment within 5.5 years was 79%.

We asked the practice about their recall system and were told they follow up the recall letters sent from a central team with a text message reminding patients their screening assessment is due.

**Monitoring care and treatment**

## There was limited monitoring of the outcomes of care and treatment.

| | Y/N/Partial |
|---|---|
| Clinicians took part in national and local quality improvement initiatives. | Yes |
| The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements. | No |
| The practice regularly reviewed unplanned admissions and readmissions and took appropriate action. | Yes |

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

The practice did not demonstrate they had identified when audits were required as part of a quality improvement programme. They had one audit in its design stage which was being undertaken regarding prescribing, but there was no data yet from this to identify improvements. All other audits related to monitoring the quantity of prescribed medicines.

We asked the practice about any actions they had taken to monitor the care and treatment of patients and were told the practice had chosen to prioritise the monitoring of patients on high risk drugs. It was explained this was because of the issues identified at the last inspection and due to not having sufficient staff to support this work. The practice were clear that they wanted to do more work on quality improvement initiatives and were trying to recruit more staff but had found this challenging due to the high risk concerns identified in April 2021 they were focusing on improving and also due to the pressures caused by the pandemic. Despite this we were told about changes made to the recall of patients with long term conditions and the work the clinical pharmacist had done to update the practice about antimicrobial resistance and improve prescribing in this area.

**Broad Spectrum antibiotic prescribing audit**

This was a single cycle audit completed by the clinical pharmacist to review the prescribing of antibiotics in the practice. The aim was to increase awareness of antibacterial resistance among clinicians and patients; to ensure consistent prescribing by all clinicians; to promote safe antibiotic use in line with local and national guidelines; and, to reduce inappropriate use of three antibiotics (cephalosporin, quinolone and co-amoxiclav).

The first cycle looked at prescribing of high risk antibiotics over a randomly picked two week period. The audit identified:

- 31 prescriptions were issued.
- Of these, 19 prescriptions were issued as per guidance or on the recommendation of secondary care,
- In three cases, the audit identified further consideration to alternative options could have been given before deciding on the use of antibiotics.
- In nine cases, guidance was not followed and alternative medications could have been used first but were not considered.
- The clinical pharmacist provided clarification about the indications where broad spectrum antibiotics should be used.

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

Explanation of any answers and additional evidence:

At our inspection in April 2021 we found several members of staff had not had inductions and some reception staff were unaware of the tools available to prioritise patients based on their symptoms. We assessed that training was not monitored to ensure staff had the necessary competence, experience and skills to carry out their role and staff did not have protected time to complete mandatory training.

At this inspection we found significant improvements to the delivery and monitoring of training. All staff were up to date with their training and there was a system to identify when it was due to expire. We spoke with staff who confirmed protected time was available to complete mandatory training.

The practice had recruited administration staff. We examined the recruitment files of two new members of staff and saw evidence that they had received inductions. We also saw evidence of appraisals and when we spoke with new staff they confirmed they were due to have appraisals once their probation period was completed.

The practice told us that all staff involved in advanced clinical practice have a nominated supervisor and for those staff who were non-medical prescribers, the nurse and clinical pharmacist, their prescriptions were double checked by the patients registered GP. Non-medical prescribing is the term used to describe any prescribing by a healthcare professional other than a doctor or a dentist.

**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. | Yes |
| Patients received consistent, coordinated, person-centred care when they moved between services. | Yes |

**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. | Yes |
| Staff encouraged and supported patients to be involved in monitoring and managing their own health. | Yes |
| Patients had access to appropriate health assessments and checks. | Yes |
| Staff discussed changes to care or treatment with patients and their carers as necessary. | Yes |
| The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity. | Yes |

Explanation of any answers and additional evidence:

We asked the practice how they supported patients to live healthier lives and were told the practice has two social prescribers (also known as link workers). A social prescriber provides non-medical advice and direct patients to facilities and services in the community which can improve health and wellbeing. Patients could request a referral from the practice.

The practice also had a mental health support worker attached to the practice who supported patients with problems such as depression and low mood.

During the inspection we reviewed the the practice website which had links to NHS videos giving information about diseases and health conditions, however for some videos the links were broken and for others the link didn't take patients to the correct one.

**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. | Yes |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. | Yes |
| Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. | No |

Explanation of any answers and additional evidence:

We reviewed three Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decision records during this inspection. In all three there was a record of a discussion with the patient about the decision, however, one of these records had not been reviewed in the last 12 months. Our specialist advisor also found an example of a review not taking place. Ongoing monitoring is required to ensure the decision remains appropriate. We discussed this with the practice and they acknowledged there was not an appropriate system to ensure an annual review of DNACPRs always took place.

# Caring Rating: Good

**Kindness, respect and compassion**

**Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.**

| Patient feedback | |
|---|---|
| **Source** | **Feedback** |
| CQC website | During the inspection we invited patients to share feedback about their experience when they needed to use the practices' services. We received responses from 20 patients and of these 10 were positive, eight were negative and two were mixed.<br><br>Patients reported that the staff were kind, caring and supportive and gave them the time that they needed. Another theme was that clinical staff generally gave detailed and thorough explanations about the symptoms patients' had and any future treatment needed for their health condition.<br><br>However, there were multiple complaints about patients finding it hard to contact the practice via the telephone. The respondents reported long wait times and when they did get through, appointments were not available. The practice operated a same day appointment system and patients said the phone lines were extremely busy first thing in the morning and if they didn't get an appointment then, they had to wait until the next day to try again.<br><br>There were also reports that some patients felt they had needed to ask for referrals to a specialist instead of it being recommended to them by the clinician. Some patients had decided to arrange this with a private provider themselves. |
| NHS website | During the inspection we reviewed patients' feedback on the NHS website. Since our last inspection in August there have been 11 reviews. Of these there were three five star, one two star and seven one star reviews.<br><br>The positive feedback related to the efficiency of the flu vaccination service, the kindness of staff, the newly introduced callback system which avoids patients having to wait on the phone for their turn, and reasonable adjustments made to assist a deaf patient.<br><br>The negative reviews concerned difficulties accessing the practice on the telephone, problems obtaining prescriptions, and challenges patients had experienced getting ongoing monitoring checks completed. |

**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) | 85.9% | 92.6% | 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) | 85.3% | 92.1% | 88.4% | No statistical variation |
| 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) | 95.4% | 97.3% | 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) | 66.2% | 88.1% | 83.0% | Variation (negative) |

| Any additional evidence or comments |
|---|
| We asked the practice if they were aware of the results of the GP patient survey and which areas they needed to focus on to improve patient satisfaction. We were told the practice was working closely with the Patient Participation Group (PPG) to better understand the reasons for this feedback. The practice explained they were working on a new website and with the PPGs support were using social media more to communicate with patients.<br><br>The practice also told us a lot of their patients want to see a GP in person which was challenging because demand exceeded the availability of appointments. However in June 2021 the practice created five pre-bookable face to face appointments to meet patient's preferences. In addition the practice told us they were working with the PPG to provide explanation about the different roles of staff in the practice and that sometimes a GP wasn't the most appropriate clinician to see. |

| Question | Y/N |
|---|---|
| The practice carries out its own patient survey/patient feedback exercises. | Yes |

| Any additional evidence |
|---|
| We asked how the practice gathered feedback from patients and were told the practice conducts a survey. However because of the pandemic and the issues identified at the last inspection in April, the practice had been focusing on reducing any risks to patients and hadn't done a survey this year. They told us they were working closely with the PPG to identify opportunities to improve patients' experience. |

**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. | Yes |
| Staff helped patients and their carers find further information and access community and advocacy services. | Yes |

| Source | Feedback |
|---|---|
| Patient feedback | Because of the methodology used in this inspection we did not interview patients. We invited patients to share feedback about their care via our website and have reviewed this as part of the inspection and have commented on it earlier in the report. |

**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) | 89.3% | 95.4% | 92.9% | No statistical variation |

| | Y/N/Partial |
|---|---|
| Interpretation services were available for patients who did not have English as a first language. | Yes |
| Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations. | Yes |
| Information leaflets were available in other languages and in easy read format. | Yes |
| Information about support groups was available on the practice website. | Yes |
| Explanation of any answers and additional evidence:<br>We reviewed the practice website which provided information for patients, their families and carers. This included details of charities, fact sheets and links to websites for specific long term conditions such as cancer, coronary heart disease (CHD), osteoarthritis, pain, stroke, diabetes and chronic obstructive pulmonary disease (COPD). | |

| Carers | Narrative |
|---|---|
| Percentage and number of carers identified. | At the time of this inspection the practice had 14,517 patients registered. Of these, 243 (1.67%) were registered as carers. This was a reduction from 310 carers in October 2019, however we were told the practice list had reduced since our last inspection. |
| How the practice supported carers (including young carers). | The practice told us they identified carers at the point of registration. We saw evidence on the website of support the practice provided to carers, such as vaccinations and signposting to support groups for long term conditions such as asthma, cancer, diabetes and mental health.<br><br>We were told young carers could be referred to the social prescriber to discuss referrals for additional support. |
| How the practice supported recently bereaved patients. | We were told that when a patient passed away staff were informed of the death and the practice sent a letter of condolence and offer of support to the bereaved relatives. |

**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. | Yes |
| There were arrangements to ensure confidentiality at the reception desk. | Yes |

# Responsive Rating: Requires Improvement

**Responding to and meeting people's needs**

## The practice did not always organise and deliver 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. | Partial |
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided. | Yes |
| The facilities and premises were appropriate for the services being delivered. | Yes |
| The practice made reasonable adjustments when patients found it hard to access services. | Yes |
| There were arrangements in place for people who need translation services. | Yes |
| The practice complied with the Accessible Information Standard. | Yes |
| Explanation of any answers and additional evidence:<br><br>Local care home staff reported that their residents who were registered at Botley Medical Centre were not always supported appropriately by the practice. They informed us that the residents did not always have their needs responded to when required. They informed us that there were delays in receiving prescriptions when they were needed. This meant staff had to access out of hours services to seek the prescriptions they needed. | |

| Practice Opening Times | |
|---|---|
| **Day** | **Time** |
| Opening times: | |
| Monday | 8:00 to 18:30 |
| Tuesday | 8:00 to 18:30 |
| Wednesday | 8:00 to 18:30 |
| Thursday | 8:00 to 18:30 |
| Friday | 8:00 to 18:30 |
| | |
| Appointments available: | |
| Monday | 7:30 to 19:30 |
| Tuesday | 7:30 to 19:30 |
| Wednesday | 7:30 to 18:30 |
| Thursday | 7:30 to 18:30 |
| Friday | 7:30 to 18:30 |
| | |

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

- Staff reported frequently using local social prescribing services (alternative support for patients in local community settings). This included when patients may be in crisis or require support that clinicians cannot offer. Staff were aware of when and how to use the service.
- The practice had access to and used a local mental health support worker when patients with specific mental health conditions or moments of crisis required additional support.
- The practice worked with palliative care teams when patients were placed on the palliative care register. Reviews of people's needs were undertaken using a multidisciplinary approach.
- The practice had implemented an online consultation and care resource to provide additional appointments for patients.
- Extended hours appointments were provided and advertised on the website. These included early morning or event appointments with the healthcare assistant, nurses or GPs.
- People in vulnerable circumstances were able to register with the practice, including those with no fixed abode such as homeless people and Travellers. However, a senior member of the reception team was not aware of the process required to enable these patients to access the service.
- Patients with specific needs a vulnerabilities were flagged/alert to staff on the clinical record system, including to reception staff. This enabled staff to prioritise and meet people's needs, such as those with sensory impairments or specific disabilities.
- There was a translation service available for staff to support patients who did not speak English as their first language.
- Patients were able to request repeat prescriptions online. However, patient feedback suggested delays and inaccurate prescribing was taking place. This was also reported by local care home staff and pharmacies.
- The practice website contained links to the practice patient information leaflet in alternative languages. However, the documents had been archived and were not available for patients who may require this service.

**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 |
|---|---|
| Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice | Partial |
| The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online) | Yes |
| Patients were able to make appointments in a way which met their needs | Yes |
| There were systems in place to support patients who face communication barriers to access treatment | Yes |
| Patients with most urgent needs had their care and treatment prioritised | Yes |
| There was information available for patients to support them to understand how to access services (including on websites and telephone messages) | Yes |

Explanation of any answers and additional evidence:

The practice identified that there was poor feedback regarding phone access and booking appointments. In November 2021 they implemented a new system for phone queueing designed to improve patients experience when calling the service. Data from November 2021 identified that of 11,740 inbound calls, 7,030 were queued and of those 3,082 were unanswered or 'missed from the queue'. The new system was designed to enable patients to receive a call back from the practice if they were held in a phone queue. Data provided to us from December showed that nearly all patients who were held in a phone queue received a call back when this system was active. The data suggested that nearly all patients accepted the call back . For example from 8 to 10 December there were 230 calls queued where the patient was then eligible for a call back. Of these 223 accepted the call back.

Patient feedback directly to CQC and provided on NHS Choices indicated difficulty in booking appointments and accessing phone lines. However, during November and December 2021 there was a reduction in negative feedback regarding phone and appointment access.

**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) | 65.2% | N/A | 67.6% | No statistical variation |
| 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) | 57.8% | 78.0% | 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) | 53.3% | 73.3% | 67.0% | No statistical variation |
| 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) | 71.5% | 86.1% | 81.7% | No statistical variation |

| Source | Feedback |
|---|---|
| For example, NHS Choices | During November and December 2021, CQC received feedback from 23 patients regarding their experiences at Botley Medical Centre. There were 13 positive comments regarding staff and the care patients received. There were also 11 comments about poor access to phones and appointments, and seven comments regarding care including problems with prescriptions. |

**Listening and learning from concerns and complaints**

## Complaints were listened and responded to

| Complaints | |
|---|---|
| Number of complaints received in the last year. | 37 (since April 2021) |
| Number of complaints we examined. | 2 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 2 |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman. | unknown |

| | Y/N/Partial |
|---|---|
| Information about how to complain was readily available. | Yes |
| There was evidence that complaints were used to drive continuous improvement. | Yes |

Example(s) of learning from complaints.

| Complaint | Specific action taken |
|---|---|
| Complaints regarding access to appointments. | There had been a practice manager allocated to investigating complaints since July 2021. They informed us they had to work through the backlog of complaints in order to review and respond to patients who had complained before they started working at the practice. The practice discussed complaints in clinical meetings and identified actions required. For example, the changes to the phone system had been implemented due to patient feedback and complaints. |

## Well-led Rating: Requires improvement

At our last inspection in April 2021 we found the practice did not operate adequate governance processes. There was limited identification of poor performance and risk to patients. We rated the practice inadequate for being well-led.

At this inspection we found significant improvement in governance processes. The practice had implemented systems to monitor areas where CQC previously identified high risk. There were examples of processes the practice had implemented where they had independently identified risks and the requirements to improve. However, there was limited clinical audit activity to identify improvements to clinical care. The practice was still in the process of identifying means by which to improve patient experience, including access to the service. We rated the practice requires improvement for providing well-led services.

**Leadership capacity and capability**

### Leaders did 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. | Partial |
| They had identified the actions necessary to address these challenges. | Partial |
| Staff reported that leaders were visible and approachable. | Yes |
| There was a leadership development programme, including a succession plan. | Yes |

Explanation of any answers and additional evidence:

The partnership had sought support from external sources including a local primary healthcare provider. They had also tried to recruit new clinical staff including GPs. Due to factors including a national shortage of GPs, they had not been successful in expanding their GP numbers, but had recruited to the nursing team. In order to provide additional care resources for patients they had implemented additional systems such as external online clinical consultations from a national independent provider. This demonstrated they had been proactive in meeting the challenges they faced. The practice had recruited several staff to the administration and reception staff teams. Daily tasks were being managed and monitored. There was an improved understanding of performance (such as completion of daily tasks) by the partners and managers since April 2021.

**Vision and strategy**

### The practice had an improved vision and 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. | Yes |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Yes |
| Progress against delivery of the strategy was monitored. | Yes |

Explanation of any answers and additional evidence:

The practice had spent much of the last six months since their last inspection improving the areas of greatest risk. This was a challenge due to the extent of problems we identified, the lack of governance in place at that time and the pressures related to the Covid 19 pandemic. In this context, long term planning was secondary to the immediate improvements required. The partners acknowledged the need for a sustainable business plan including expanding the leadership and clinical teams.

**Culture**

## The practice had an improved culture.

| | Y/N/Partial |
|---|---|
| There were arrangements to deal with any behaviour inconsistent with the vision and values. | Yes |
| Staff reported that they felt able to raise concerns without fear of retribution. | Yes |
| There was a strong emphasis on the safety and well-being of staff. | Yes |
| There were systems to ensure compliance with the requirements of the duty of candour. | Yes |
| When people were affected by things that went wrong, they were given an apology and informed of any resulting action. | Yes |
| The practice encouraged candour, openness and honesty. | Yes |
| The practice had access to a Freedom to Speak Up Guardian. | Yes |
| Staff had undertaken equality and diversity training. | Yes |

Explanation of any answers and additional evidence:

Staff reported a significant improvement in the practice culture. They reported feeling able to openly report concern via incident reporting and that they received feedback about learning outcomes. There was a more open and transparent culture.

The practice had reviewed their whistleblowing policy and communicated this with staff via meetings. However, the policy did not adequately provide information on how to raise concerns externally should staff feel any issues raised were not appropriately addressed by leaders within the practice.

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

| Source | Feedback |
|---|---|
| Staff interviews | The staff working in support roles indicated that there was an improved working environment, improved support from leaders and manageable workloads in recent months. Staff reported that when workloads became difficult to manage there was acknowledgement from the leadership team and changes made to address backlogs. They acknowledged there were still challenges working in the practice. |

**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. | Partial |

| | |
|---|---|
| Staff were clear about their roles and responsibilities. | Yes |
| There were appropriate governance arrangements with third parties. | No |

Explanation of any answers and additional evidence:

The practice had significantly improved monitoring processes regarding the management on ongoing care tasks such as monitoring high risk prescribing and patients requiring interventions for their long term conditions. There were concerns we identified which had not been identified by governance arrangements. For example, patients with Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions on their medical records did not always received annual reviews as required by national guidance.

**Managing risks, issues and performance**

## There were improved processes for managing risks, issues and performance.

| | Y/N/Partial |
|---|---|
| There were comprehensive assurance systems which were regularly reviewed and improved. | Yes |
| There were processes to manage performance. | Yes |
| There was a quality improvement programme in place. | No |
| There were effective arrangements for identifying, managing and mitigating risks. | Yes |
| A major incident plan was in place. | Yes |
| Staff were trained in preparation for major incidents. | Yes |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Partial |
| Explanation of any answers and additional evidence:<br><br>There was limited identification of required clinical quality improvement including limited clinical audit. | |

## 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. | Yes |
| The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access. | Yes |
| There were systems in place to identify and manage patients who needed a face-to-face appointment. | Yes |
| The practice actively monitored the quality of access and made improvements in response to findings. | Yes |
| There were recovery plans in place to manage backlogs of activity and delays to treatment. | Yes |
| Changes had been made to infection control arrangements to protect staff and patients using the service. | Yes |
| Staff were supported to work remotely where applicable. | Yes |
| Explanation of any answers and additional evidence: | |

There had been changes to the appointment types and systems used to book appointments. Monitoring of the phone system had improved and changes were being implemented to improve the experience for patients queueing on phones.

**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. | Yes |
| Performance information was used to hold staff and management to account. | Yes |
| Staff whose responsibilities included making statutory notifications understood what this entailed. | Yes |

## 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. | Yes |
| The provider was registered as a data controller with the Information Commissioner's Office. | Yes |
| Patient records were held in line with guidance and requirements. | Yes |
| Patients were informed and consent obtained if interactions were recorded. | Yes |
| The practice ensured patients were informed how their records were stored and managed. | Yes |
| Patients were made aware of the information sharing protocol before online services were delivered. | Yes |
| The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services. | Yes |
| Online consultations took place in appropriate environments to ensure confidentiality. | Yes |
| The practice advised patients on how to protect their online information. | Yes |

**Engagement with patients, the public, staff and external partners**

## The practice involved did involve the public, staff and but did not always engage well with external partners to sustain high quality and sustainable care.

| | Y/N/Partial |
|---|---|
| Patient views were acted on to improve services and culture. | Partial |
| The practice had an active Patient Participation Group. | Yes |
| Staff views were reflected in the planning and delivery of services. | Yes |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Partial |

Explanation of any answers and additional evidence:

The partners were not always fully engaged in the experiences of patients and stakeholders. For example, there was a difference in the perception of how well prescriptions were managed between the practice and local stakeholders.

There was improved engagement with the Patient Participation Group. However, the practice had not fully engaged with the experiences of patients through extensive feedback such as surveys.

Feedback from Patient Participation Group.

| Feedback |
|---|
| We spoke with a member of the PPG who told us, because of the pandemic, meetings took place virtually. They told us they believed the practice were beginning to value the PPG more and were engaging with them more actively. They shared feedback that patients were finding it difficult to get appointments because of long waiting times on the phones. The PPG told us they understood the need to use more telephone appointments because of the pandemic. They were working with the practice and making suggestions on how to improve phone access.<br><br>The PPG shared feedback that some patients had experienced a long wait even when they chose the callback option in the telephone queueing system and they would prefer to be called only when it was their turn. The practice responded by making this change.<br><br>The PPG told us they were very impressed with the way the COVID-19 and flu vaccination programmes were managed during the pandemic. They told us it was efficient and they felt safe when they got their vaccines. |

**Continuous improvement and innovation**

## There was some evidence of systems and processes for learning, continuous improvement and innovation. However, there was limited identification of improvements to clinical care beyond CQC inspection findings.

| | Y/N/Partial |
|---|---|

| | |
|---|---|
| There was a strong focus on continuous learning and improvement. | No |
| Learning was shared effectively and used to make improvements. | Yes |

**Examples of continuous learning and improvement**

Since April 2021 the practice had taken action to meet essential standards of care:

- Implemented a new monitoring system for high risk medicines.
- Made changes to their phone access system for patients to receive call backs when queued.
- Improved access by diversifying access to virtual consultations including appointments with an independent provider.
- Improved the monitoring and processing of daily tasks.
- Recruited new staff and provided them with inductions and ensured existing staff had training they required.

The practice informed us they had limited opportunity to make other improvements due to the pressures of the pandemic and the improvement actions they needed to make.

**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) | ≤-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.
- 
- ‰ = per thousand.