

Care Quality Commission

Inspection Evidence Table

Snodland Medical Practice (1-547266550)

Inspection date: 29 September 2022

Date of data download: 27 September 2022

Overall rating: Good

Safe

Rating: Good

Safety systems and processes

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

| Safeguarding | Y/N/Partial |
|--|-------------|
| 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 |
| 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 |
| Explanation of any answers and additional evidence: The practice had designated safeguarding leads. All staff knew how to identify and report concerns. There were safeguarding policies that were accessible to staff and outlined who to contact if staff had concerns about a patient's welfare. We looked at the training records of five staff members and found that all staff were up to date with safeguarding training appropriate to their role. The practice had a safeguarding register. The practice's computer system alerted staff of children that were on the risk register as well as family and other household members of children on the risk register. There were notices around the practice and in clinical rooms advising patients that chaperones were available. We saw that staff who acted as chaperones were trained for the role. | |

| Safeguarding | Y/N/Partial |
|---|-------------|
| We saw that staff had received Disclosure and Barring Service (DBS) checks (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). | |

| Recruitment systems | Y/N/Partial |
|---|-------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Yes |
| Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role. | Yes |
| Explanation of any answers and additional evidence: We looked at the vaccination records of five members of staff and found that staff vaccination was maintained in line with current guidance. | |

| Safety systems and records | Y/N/Partial |
|---|-------------|
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 18 August 2022 | Yes |
| There was a fire procedure. Date of fire risk assessment: 22 September 2022 | Yes |
| Actions from fire risk assessment were identified and completed. | Yes |
| Explanation of any answers and additional evidence: We saw that the provider had completed a health and safety risk assessment on 18 August 2022. The risk assessment identified three actions that needed to be completed. For example, identity cards should be worn at all times by visitors. It was unclear from the risk assessment that these actions had been completed. After the inspection, the provider wrote to us with an action plan to show the actions had either been completed or had a date for completion. The provider had completed a fire risk assessment on 22 September 2022. The risk assessment identified three actions that needed to be completed. For example, equipment should be removed from the area under the stairs. It was unclear from the risk assessment that these actions had been completed. After the inspection, the provider wrote to us with an action plan to show all actions had a realistic date for completion. Records showed that calibration testing of equipment and portable appliance testing (PAT) had been carried out within the last 12 months. The provider had a fire evacuation plan, completed testing of the fire alarm system and carried out fire drills. The most recent fire drill took place on 22 September 2022. As a result of this fire drill, the provider identified five actions that needed to be taken. For example, there were two trained fire marshals at the practice. The action plan identified that it would be beneficial for the fire marshals to attend refresher training and for an additional two members of staff to receive fire marshal training. The provider had an action plan, including a date for completion for these actions. | |

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. Date of last infection prevention and control audit: 16 September 2022. | 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. | Yes |
| Explanation of any answers and additional evidence: The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. We looked at the training records of five staff members and saw they had received appropriate training in infection prevention and control (IPC). Records showed the provider had completed an IPC audit which identified two actions that the provider needed to take. For example, the provider had identified some non-clinical waste bins in the practice were not pedal-operated and lidded, as per best practice guidance. The provider had an action plan showing how this would be rectified. Following the inspection, the provider wrote to us with evidence that non-clinical waste bins with lids and pedals were now in use at the practice. | |

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: There was an induction system for all new staff. The practice had a comprehensive business continuity plan for major incidents such as; power failure or building damage. The plan included emergency contact numbers for staff. We looked at the training records of five members of staff and found four of these staff members had completed basic life support training appropriate to their role. One of the training records we looked at was for a non-clinical member of staff who had not completed basic life support training. This staff member had been employed by the practice within the last month and had basic life support training scheduled for 18 October 2022. | |

Training records showed that staff had received training in the recognition and management of patients with potential sepsis appropriate to their role.

We saw there was an inventory of emergency equipment and that regular monitoring took place. The provider held two sets of adult defibrillator pads and one set of paediatric defibrillator pads. After the inspection, the provider sent us evidence that an additional set of paediatric defibrillator pads had been purchased for use in the practice.

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. ¹ | 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: | |
| Review of patient records identified that care records were managed in line with current guidance. | |
| Referrals were appropriate and managed in a timely manner. | |
| We saw examples where discussions were held between the provider and health visitors regarding children on the risk register. | |

Appropriate and safe use of medicines

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

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

| 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) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA) | 0.81 | 0.85 | 0.82 | No statistical variation |
| The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA) | 12.8% | 8.9% | 8.5% | Tending towards variation (negative) |
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA) | 4.52 | 5.77 | 5.31 | No statistical variation |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA) | 161.9‰ | 132.5‰ | 128.0‰ | No statistical variation |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA) | 0.64 | 0.61 | 0.59 | No statistical variation |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA) | 9.9‰ | 6.8‰ | 6.8‰ | No statistical variation |

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

| Medicines management | Y/N/Partial |
|---|-------------|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | 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 and Improvement 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. | 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. | 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 UKHSA guidance to ensure they remained safe and effective. | Partial |
| <p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>The provider was aware prescribing of 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 was higher than local and national averages. The provider recognised the need to regularly review these patients and completed annual audits on high-risk antibiotic prescribing.</p> <p>We found that 10 patients were prescribed leflunomide. All of these patients had received the required blood tests, however four of these patients required other monitoring tests such as blood pressure and weight. After the inspection the provider wrote to us with evidence that all of these patients had the required monitoring, or had appointments scheduled for these tests.</p> <p>We reviewed the records of five patients who had been prescribed potassium sparing diuretic and found that best practice guidance had been followed for the monitoring of these patients.</p> <p>We saw there was an inventory of emergency medicines held and regular monitoring took place. The provider did not have the following emergency medicines on the day of inspection; atropine;</p> | |

| Medicines management | Y/N/Partial |
|--|-------------|
| <p>dexamethasone or soluble prednisolone; or midazolam buccal or rectal diazepam. The provider had completed risk assessments to demonstrate how the risks of not holding these medicines had been managed. After the inspection the provider wrote to us with evidence that all three of the medicines identified had been purchased for use in the practice.</p> | |
| <p>The provider held medical oxygen and a defibrillator on site, we saw evidence of regular monitoring of these.</p> | |
| <p>The provider had four refrigerators for the storage of vaccines. The temperatures of these refrigerators were monitored and recorded regularly. Records showed the temperatures of one of the refrigerators had been recorded as being outside of the acceptable limits of between two and eight degrees centigrade on 8 March 2022. We saw evidence that appropriate action had been taken. A significant event was recorded as a result, the practice's cold chain policy was updated and data loggers (an electronic device that records temperature over a defined period of time) were purchased for use with the refrigerators. Records for another refrigerator showed the temperatures were recorded as being outside of acceptable limits on two occasions; 3 August 2022 and 12 September 2022. We looked but could not find evidence of action taken on either of these occasions. The provider wrote to us after the inspection with evidence that this incident had been retrospectively investigated and recorded as a significant event. The investigation concluded that the temperature of the refrigerator had been outside of the acceptable limit for less than 20 minutes, which was not in breach of the cold chain guidance from Public Health England. We saw evidence that this incident had been shared with staff as a reminder of the actions to take should an out of range temperature be recorded.</p> | |

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

| Significant events | Y/N/Partial |
|--|-------------|
| The practice monitored and reviewed safety using information from a variety of sources. | 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: | 8 |
| Number of events that required action: | 8 |
| <p>Explanation of any answers and additional evidence: We looked at six significant events that had been recorded in the last 12 months. We saw the events had been investigated, escalated to the GP partners where necessary, discussed in clinical meetings and action taken. We saw lessons learned were shared with staff via email and in staff meetings.</p> | |

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

| Event | Specific action taken |
|--|--|
| A patient required a tetanus booster, attended the practice and was told that the vaccine was out of date. The patient was referred to the hospital for a tetanus vaccination. | This incident was investigated and it was found that the expiry date for the vaccine was the current month. The staff member was not aware that this meant that the vaccine could be used until the last day of the month. Therefore, the vaccine could have been given to the patient. This information was shared with staff members with responsibilities for administering vaccines, as well as the wider practice team. |
| Prescription stationery was not recorded correctly. It was identified that no action had been taken where errors were found with prescription batch numbers. | This was identified by a practice audit. The management team created an electronic register and the policy was updated. Only prescription clerks or management were permitted to remove and sign out blank prescription forms. The updated policy and procedure were shared with practice staff. |

| Safety alerts | Y/N/Partial |
|--|-------------|
| There was a system for recording and acting on safety alerts. ¹ | Yes |
| Staff understood how to deal with alerts. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>The practice had a system for receiving, sharing and acting on safety alerts. Staff we spoke with understood how to process these alerts.</p> <p>We looked at the records of five patients aged 65 years or over and were prescribed citalopram (greater than 20 mg). We found that all patients had the risks of this medicine explained to them.</p> | |

Effective

Rating: Good

QOF requirements were modified by NHS England and Improvement 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 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. | Partial |
| 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 prioritised care for their most clinically vulnerable patients. | Yes |
| Explanation of any answers and additional evidence: During our inspection, we completed a series of searches on the practice's clinical records system. These searches were completed with consent and to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance. We looked at five patients identified by the search as having a potential missed diagnosis of diabetes and five patients with chronic kidney disease stages 4 or 5. We found that the monitoring and management of these patients was carried out in line with best practice guidance. We looked at five medicine reviews and found that these were completed to a high standard and offered as face-to-face appointments. We looked at five patients who had been prescribed gabapentinoids and found that two of these patients required a medicine review. We shared these findings with the provider who wrote to us with evidence that one of these patients had a medicine review appointment scheduled. One patient had attended for a medicine review. | |

We reviewed five patients with asthma who had been prescribed two or more courses of rescue steroids. We found that four of these patients had received the appropriate reviews and one patient needed an asthma review. After the inspection the provider wrote to us with evidence that an asthma review had been scheduled for this patient.

We reviewed five patients with hypothyroidism and found that one of these patients had not had the required monitoring tests. We shared this with the provider who wrote to us with evidence that an appointment had been scheduled for this patient.

We looked at five patients with diabetic retinopathy (diabetic retinopathy is a complication of diabetes, caused by high blood sugar levels damaging the back of the eye. It can cause blindness if left undiagnosed and untreated). One patient appeared to require an annual review, however the provider showed us evidence that this had been reviewed at the hospital. The remaining four patients had received annual reviews.

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.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice 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.
- Carers were offered annual health checks.

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.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

| 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) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 150 | 163 | 92.0% | 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) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 140 | 153 | 91.5% | 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) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 140 | 153 | 91.5% | Met 90% minimum |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 140 | 153 | 91.5% | Met 90% minimum |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 124 | 136 | 91.2% | 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

Childhood immunisations were carried out in line with the national childhood vaccination programme. NHS England results (published in March 2021) showed that uptake rates were higher than the World Health Organisation (WHO) minimum target of 90% for five indicators.

| Cancer Indicators | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency) | 70.9% | N/A | 80% Target | Below 80% target |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA) | 53.6% | 63.4% | 61.3% | N/A |
| Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA) | 65.9% | 68.0% | 66.8% | N/A |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA) | 66.2% | 56.4% | 55.4% | No statistical variation |

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

| Any additional evidence or comments |
|---|
| <p>Published results showed that the provider's uptake for cervical cancer screening as at March 2022 was below the 80% target for the national screening programme.</p> <p>The provider told us that in an attempt to increase uptake for cervical screening; they regularly reviewed the updated figures and sent recall text messages to remind patients of the need to book an appointment; and used opportunistic appointment bookings, when a patient attended the practice for other matters. Unverified data showed that the provider's uptake for cervical cancer screening as of September 2022 was 67% of eligible patients, with six months remaining to reach the target of 80%.</p> |

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. | Yes |
| The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements. | Yes |
| 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 provider sent evidence of clinical audits that were part of an overarching programme. Records showed that eight clinical audits had been carried out in the last two years. For example, an audit had been conducted on Type 2 diabetes and cardiovascular risk, which aimed to optimise outcomes for patients diagnosed with Type 2 diabetes. Patients were invited for a review with the clinical pharmacist who worked with the lead GP for diabetes management to complete medicine reviews for 78 eligible patients. The outcome of this intervention showed improvements in the management of diabetes (49% of patients), lipids (25% of patients) and hypertension (21% of patients).

The provider had completed a quality improvement project looking at the prevalence of certain diseases within the practice population. The aim of this project was to ensure patients were coded correctly so that patients received appropriate monitoring. The outcome of this project was that the register sizes for these diseases increased to a level that was comparable with national averages. For example, the provider identified an additional 34 patients with asthma, 224 patients with chronic kidney disease and 38 patients with heart failure.

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: | |
| There was a programme of essential training including, fire safety, infection prevention and control and mental capacity act. Records viewed showed that staff had completed this training. | |

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 |
| Explanation of any answers and additional evidence: Meetings were held each fortnight with practice staff, district nurses, social workers and social prescribers. Complex cases were discussed at these meetings, the minutes of which were available to the Kent and Medway Integrated Care System. | |

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: The practice had a designated administrative lead for patients who may need extra support. This included patients with learning disabilities; patients with mental health concerns or dementia; patients who were housebound or frail; patients in the last 12 months of their lives; and carers. The patients identified were given a direct dial number for the administrative lead to allow for ease of access to appointments and were directed to relevant services. The register included information such as the preferred method of communication and if the patient had a carer who arranges appointments for them. The practice had a system where patients who were housebound were visited regularly at home by their named GP. Each patient was seen at home at least once per year, however patients identified as higher risk were visited more regularly. Staff at the practice told us that they book annual reviews for patients on the dementia register on the same day as other health checks such as diabetes or COPD. The practice referred eligible patients to a diabetes prevention programme. Carers were actively encouraged to attend annual health checks and flu immunisation. | |

We saw posters in the practice waiting room which gave information about how patients could manage their own health. For example; smoking cessation, wellbeing checks and healthy living services. There was also information about support available through services for mental health, sexual health, diabetes prevention and addiction.

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. ¹ | Yes |
| <p>Explanation of any answers and additional evidence.</p> <p>We reviewed three patient records where a DNACPR decision had been recorded. This identified that where a DNACPR decision had been recorded, patient views had been sought and respected. We saw there was a clear rationale for the decision that was not discriminatory nor based on assumptions about the person's quality of life.</p> | |

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.

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

| Patient feedback | |
|---|---|
| Source | Feedback |
| NHS reviews website | There were seven reviews on the NHS website. Three of these reviews gave five out of five stars and commented on the brilliant service received, positive experience of a referral and treatment for cancer, and the cleanliness of the practice. Four of these reviews gave one out of five stars and commented on delays to prescriptions and difficulty accessing same day appointments. |
| Experience shared with CQC directly via our website | There were three comments received by CQC which referred to difficulty accessing prescriptions. |

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

| 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 (01/01/2022 to 30/04/2022) | 94.2% | 82.1% | 84.7% | Tending towards variation (positive) |
| 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 (01/01/2022 to 30/04/2022) | 93.2% | 80.8% | 83.5% | Tending towards variation (positive) |
| 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 (01/01/2022 to 30/04/2022) | 93.4% | 92.0% | 93.1% | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022) | 77.1% | 66.8% | 72.4% | No statistical variation |

Any additional evidence or comments

Feedback about the practice from the national GP patient survey published in April 2022 was positive and in line with local and England averages.

Question

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

Y/N

Yes

Any additional evidence

The provider had carried out a patient survey in September 2022, which was completed by 198 patients. Unverified data showed that patients responded positively regarding their experience at the practice. For example, 179 patients (88.6%) felt listened to when explaining their conditions or symptoms; 185 patients (91.6%) said that the communication skills of the clinician they were seeing were good, very good or excellent; and 170 patients (80%) rated the welcome and helpfulness of reception staff as good, very good or excellent.

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 |
| Explanation of any answers and additional evidence: The provider worked with community services to support vulnerable groups. For example, "The Men's Mind Project" which supports men with their mental health and the "Be Me Project" which supports young people to build positive mental wellbeing and self-confidence. Patients were signposted to these support groups where appropriate, and facilitators at these groups encouraged people to visit their GP if they had concerns. | |

| Source | Feedback |
|---------------------------|--|
| Interviews with patients. | Patients told us that staff were caring and they were treated with respect by clinical and non-clinical staff. |

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

| 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 (01/01/2022 to 30/04/2022) | 93.8% | 89.0% | 89.9% | No statistical variation |

Any additional evidence or comments

Feedback about the practice from the national GP patient survey published in April 2022 was positive and in line with local and England averages.

| | 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: | |
| Letters and information were available in easy read format. | |
| Interpretation services were available, including British Sign Language interpreters who were available to accompany patients to appointments. | |

| Carers | Narrative |
|---|---|
| Percentage and number of carers identified. | The practice had identified there were 242 carers in the practice (2% of the practice population). |
| How the practice supported carers (including young carers). | There was a designated member of staff to maintain the carers register. An alert was added to the carer's record so that carers could be supported with suitable appointment flexibility and understanding. Carers were given a direct number to this staff member to enable easy access to appointments for themselves and the people they care for. |
| How the practice supported recently bereaved patients. | A GP contacted bereaved patients by telephone. Support was offered, there were a range of options available to patients to ensure individual tailored support for example, counselling. Patients were signposted to appropriate charities for support. |

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: 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. | Yes |
| 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: The layout of the practice meant that all areas were accessible to people using wheelchairs or mobility scooters. There was a lift to the first floor of the practice. A hearing loop was available at reception. Toilets were accessible to people with limited mobility and there were designated baby changing facilities. | |

| Practice Opening Times | |
|-------------------------|-------------------------------|
| Day | Time |
| Opening times: | |
| Monday | 8am-7.30pm |
| Tuesday | 8am-7.30pm |
| Wednesday | 8am-6.30pm |
| Thursday | 8am-6.30pm |
| Friday | 8am-6.30pm |
| Appointments available: | |
| Monday | 8am-12.30pm and 1.15pm-7.30pm |
| Tuesday | 8am-12.30pm and 1.15pm-7.30pm |
| Wednesday | 8am-12.30pm and 1.15pm-6.30pm |
| Thursday | 8am-12.30pm and 1.15pm-6.30pm |
| Friday | 8am-12.30pm and 1.15pm-6.30pm |

| Further information about how the practice is responding to the needs of their population |
|---|
| <ul style="list-style-type: none"> • Patients had a named GP who supported them 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. |

- Additional nurse appointments were available until 7pm on a Monday for school age children so that they did not need to miss school.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- 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 able to access care and treatment in a timely way.

| | 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 | Yes |
| 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 (including those who might be digitally excluded). | 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 |
| <p>Explanation of any answers and additional evidence:</p> <p>There were multiple appointment types available, including face to face, telephone and video consultations. Patients were able to book appointments in person, on the telephone and via eConsult (online). The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.</p> <p>On the day of inspection, we looked at the practice’s appointment system and found the next available face to face appointment with a GP was on 29 September 2022, the next available face to face appointment with a nurse was 24 October 2022, and the next available telephone appointment with a GP was 29 September 2022.</p> | |

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

| 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 (01/01/2022 to 30/04/2022) | 32.4% | N/A | 52.7% | Variation (negative) |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022) | 48.0% | 48.6% | 56.2% | 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 (01/01/2022 to 30/04/2022) | 59.3% | 48.2% | 55.2% | No statistical variation |
| The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022) | 71.1% | 68.2% | 71.9% | No statistical variation |

Any additional evidence or comments

Three indicators from the national GP patient survey published in April 2022 showed feedback was positive and in line with local and national averages. Results showed lower than average satisfaction scores with how easy it was to get through to someone at the GP practice on the telephone.

The provider had responded to negative feedback about access to the practice by installing a new telephone system in July 2022. The new system informed patients of their position in the queue and offered a callback service, where patients could select the option to hang up the telephone and receive a callback when they reach the front of the queue. The new system included a live dashboard which alerts the management team to long telephone queues so that staff can be deployed to answer the telephones at busy times.

Unverified data collected by the practice in September 2022 asked 206 patients their level of satisfaction with the waiting time for their telephone call to be answered;

- Poor/fair – 32% (66 respondents)
- Good/very good/excellent – 44.7% (92 respondents)
- N/A – 23.3% (48 respondents).

The provider had recruited a paramedic in response to high demand for same-day appointments. This led to a decrease in the urgent care workload for GPs, which resulted in a 10% increase in the number of pre-bookable appointments available with GPs.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

| Complaints | |
|--|---|
| Number of complaints received in the last year. | 9 |
| Number of complaints we examined. | 4 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 4 |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman. | 2 |

| | 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 of learning from complaints.

| Complaint | Specific action taken |
|---|---|
| Prescriptions were not completed in a timely way and patient did not receive phone call from a GP when the prescription was ready for collection. | An apology was sent to the patient which also explained that the reason for the delay was that the pharmacist and prescription clerk were working on synchronising medicines. This aimed to reduce the number of trips to the surgery and pharmacy for the patient. The provider acknowledged that communication should have been clear with the patient regarding whether they would receive a telephone call. This was shared with staff at the practice to improve communication between staff and patients. |

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

| | Y/N/Partial |
|---|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | Yes |
| They had identified the actions necessary to address these challenges. | Yes |
| 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: There was a practice manager employed by the provider, however this was an interim arrangement. Two staff members were training to become practice manager and deputy practice manager. These staff members provided cover for the practice manager when on leave. The staff completing the training programme were gradually taking on practice manager responsibilities, with supervision from the interim practice manager. | |

Vision and strategy

The practice had a clear vision and 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. | 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: Staff told us they were aware of the practices' vision, values and strategy. They understood their role in supporting the development and achievement of these. | |

Culture

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

| | Y/N/Partial |
|---|-------------|
| There were arrangements to deal with any behaviour inconsistent with the vision and values. | 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: | |
| We reviewed the training records of five staff members and found that all had completed training in equality and diversity. | |
| Staff told us that leaders were approachable and supportive. Staff felt that there was an open culture at the practice and felt comfortable raising concerns with the management team. | |

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

| Source | Feedback |
|----------------------|---|
| Staff feedback forms | We received 20 feedback forms from staff at the practice. Feedback was mostly positive with staff commenting that patients received good care, the practice was an inclusive environment with a respectful atmosphere, and the leadership team were open to suggestions. Areas for improvement were also identified. Comments from staff suggested that they would like additional face-to-face nurse and GP appointments for patients. |

Governance arrangements

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

| | Y/N/Partial |
|--|-------------|
| There were governance structures and systems which were regularly reviewed. | Yes |
| Staff were clear about their roles and responsibilities. | Yes |
| There were appropriate governance arrangements with third parties. | Yes |
| There are recovery plans in place to manage backlogs of activity and delays to treatment. | Yes |
| Explanation of any answers and additional evidence: | |
| We looked at 20 governance documents and found that they were up to date. The provider had a system to ensure the documents were reviewed regularly. | |

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

| | Y/N/Partial |
|--|-------------|
| There were comprehensive assurance systems which were regularly reviewed and improved. | Yes |

| | |
|--|---------|
| There were processes to manage performance. | Yes |
| There was a quality improvement programme in place. | Yes |
| There were effective arrangements for identifying, managing and mitigating risks. | Partial |
| 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. | Yes |

Explanation of any answers and additional evidence:
Our inspection identified that improvements were required in relation to the management of risks in relation to:

- Monitoring of refrigerator temperatures.
- Cervical cancer screening uptake.
- The prescribing of some high-risk antibiotics.

The provider had a comprehensive action plan which detailed how they were monitoring and improving systems and processes for cervical cancer screening uptake and the prescribing of some high-risk antibiotics.

After the inspection the provider wrote to us with evidence that they had reviewed and taken appropriate action on the monitoring of refrigerator temperatures and there was an action plan to continue to monitor these risks.

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 |
| Staff are supported to work remotely where applicable. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>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.</p> <p>There was a triage section on the practice's clinical systems where details of every patient who called the practice was recorded. These patients were reviewed by a clinician who determined the most appropriate action for each patient.</p> | |

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

| | Y/N/Partial |
|--|-------------|
| Patient views were acted on to improve services and culture. | Yes |
| 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. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>The practice had an active patient participation group (PPG) who held meetings with practice representatives every three months. We saw examples of where the PPG had shared ideas for improvement and actions that the provider had taken in response to these. For example, concerns had been raised about confidentiality as conversations between patients and staff at the reception desk could</p> | |

be heard by other patients in the waiting room. The provider responded by playing music in the waiting room to reduce the likelihood of conversations being heard, and staff advised patients of the room available to discuss private matters. Members of the PPG told us they felt involved in changes made at the practice, there was a good relationship between patients and staff, and treatment and care of patients was excellent.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

| | Y/N/Partial |
|---|-------------|
| There was a strong focus on continuous learning and improvement. | Yes |
| Learning was shared effectively and used to make improvements. | Yes |
| Explanation of any answers and additional evidence: GPs at the practice included those with special interests including cardiology, minor surgery, mental health and ophthalmology. Complaints and significant events were used to make improvements. We saw evidence of quarterly complaints reviews which looked for themes to identify areas for improvement. For example, one review identified repeated incidences of staff telling a patient that someone from the practice would contact them, however this contact did not always take place. This information was shared with staff so that communication between staff members could be improved. | |

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.
- **UKHSA:** UK Health and Security Agency.
- **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.