

Care Quality Commission

Inspection Evidence Table

Dr Devanna Manivasagam (1-520401751)

Inspection date: 14 September 2020 to 2 October 2020

Date of data download: 07 September 2020

Overall rating: Not rated

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

Safe

Rating: Not rated

We inspected the practice in January 2020 and rated the practice inadequate for providing safe services. The previous rating remains unchanged.

Safety systems and processes

The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	N/A
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y

Safeguarding	Y/N/Partial
<p>Explanation of any answers and additional evidence:</p> <p>There was some evidence of safeguarding systems and processes for example, designated safeguarding leads and a deputy, policies that were practice specific and accessible to staff and guidance including a flow chart for staff to refer to. There was evidence that clinical and non-clinical staff were up to date with safeguarding training appropriate to their role and safeguarding was a standing agenda item in staff meetings. Safeguarding discussions took place with the multi-disciplinary team and we saw minutes of a recent meeting on July 2020. There were systems in place to follow up children with non-attendance at secondary care services which included referring to the health visitors and examples of safeguarding referrals made. There were arrangements in place to inform the out of hours service of vulnerable people, this included forwarding a list of specified patients with special notes added to the clinical system accessible to the out of hours service.</p> <p>The practice told us that they had worked with the Clinical Commissioning Group (CCG) and local safeguarding teams to improve the practices safeguarding register. This resulted in reviewing individual patient records to ensure coding and alerts were in place correctly and registers were accurate. A member of the administrative team regularly reviewed the safeguarding registers to ensure they were up to date. All correspondences received in relation to safeguarding were coded and an alert added to the records. This included cross referencing with other members of the household who may be at risk such as children and adding corresponding alerts to their records. There were weekly safeguarding reports run which were sent to the practice manager and discussed at weekly cross site managers meetings. The system for searching safeguarding on the clinical system also included Female Genital Mutilation although at the time of the inspection the practice did not have any patients identified in this category. However, safeguarding systems were not fully embedded and the monitoring was not effective resulting in gaps and inconsistencies</p> <p>We reviewed the safeguarding register at the practice and saw examples of alerts added to records but the system in place to identify vulnerable patients on records was not consistent, we saw that information was not always up to date or accurate. The practice safeguarding register listed seven patients subject to a child protection plan. However, when we reviewed clinical records there was no evidence in the clinical records that these patients were being reviewed and monitored to ensure information was relevant. There was no evidence the practice had been proactive in reviewing or discussing any possible risks the children may be exposed to on an ongoing basis so that any action required could be promptly taken. Our review of four records demonstrated that children were not always followed up in a timely manner to determine current risks. Children living in households with history of domestic abuse had no relevant correspondences relating to the concern and had not been seen or reviewed over a year after joining the practice. The practice safeguarding registers advised that patients on the child safeguarding register had a pop-up alert on the clinical system to indicate they were at risk. We did not see that these were in place for the patients reviewed, we were told this was because pop-up alerts were no longer used on the clinical system and that information was only recorded on the home screen, we did not see any policy or procedure to support the change in practice. This may result in important information being missed by clinicians during consultations.</p> <p>We saw that staff had appropriate DBS checks in place for staff, one member of staff had a DBS from a previous employer and this had been risk assessed. Following the inspection the provider submitted an updated DBS check for the member of staff completed as part of the providers recruitment process.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence:	
The practice had sourced external support to improve and strengthen the recruitment process. We reviewed a sample of recruitment records for staff and found appropriate checks had been completed. such as Disclosure and Barring Service (DBS) checks. There was a policy for staff screening and immunisation which set out requirements for staff and risk assessment to identify any gaps and areas that needed further follow up. We saw evidence of completed risk assessment for a new member of staff.	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: April 2020	Y
There was a record of equipment calibration. Date of last calibration: April 2020	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: May 2020	Y
There was a log of fire drills. Date of last drill: August 2020	Y
There was a record of fire alarm checks. Date of last check: September 2020	Y
There was a record of fire training for staff. Date of last training: Various dates within the last 12 months	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: August 2020	Y

Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Since the last inspection the provider was utilising an adjacent building 295 Walsall Road to deliver face to face patient consultation as part of COVID-19 safety measures. This was in addition to the registered address 291 Walsall Road which was primarily used for administrative and remote work. The health and safety assessments covered both buildings. The provider was made aware of the need to update their statement of purpose to reflect the use of a new premises.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: July 2020	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: July 2020	Y
<p>Explanation of any answers and additional evidence:</p> <p>Since the last inspection the provider was utilising an adjacent building 295 Walsall Road to deliver face to face patient consultation as part of COVID-19 safety measures. This was in addition to the registered address 291 Walsall Road which was primarily used for administrative and remote work. The health and safety assessments covered both buildings. The provider was made aware of the need to update their statement of purpose to reflect the use of a new premises.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: February 2020	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>This inspection was undertaken remotely, information and evidence relating to infection, prevention and control was viewed electronically as well as visually by a screen sharing application.</p>	

The provider had an overarching infection prevention and control policy however, this lacked detail and did not include areas such as the management of sharps.

Staff had received training in infection prevention and control and training was incorporated as part of induction for newly appointed staff.

There was an infection prevention and control lead at the practice. Systems were in place to check that clinical waste bags awaiting collection were correctly labelled in line with legal requirements. There were records to confirm the cleaning of equipment used for patients care and treatment. Sharps boxes were correctly labelled to allow the containers to be identified. There was evidence of a legionella risk assessment (Legionella is a term for a bacterium which can contaminate water systems in buildings).

There were arrangements in place for managing waste and clinical specimen which were collected by an external contractor we saw evidence of consignment notes which demonstrated regular collection took place.

Stone cross medical Centre was now operating across two separate buildings as part of COVID-19 safety measures, one building was operating as an 'Amber' site for face to face patient consultation and the other was operating as a 'green' site for administrative and remote work.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Partial
Risk management plans for patients were developed in line with national guidance.	Partial
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y

Explanation of any answers and additional evidence:

Staff spoken with told us that since the recruitment of both clinical and non-clinical staff, staffing levels were sufficient to manage busy periods and absences within the team and additional support was available across the providers various practices (sites).

Since the last inspection the provider had taken action to strengthen the workforce across sites. This included the appointment of a GP partner in addition to a practice manager and nurse at each practice. A clinical pharmacist also an independent prescriber worked across all sites. Two administrative staff were undergoing training as health care assistants, one of whom would be working at Stone Cross Medical Centre. There were long term locum GPs in post who worked regular shifts at each practice. The IT manager and a salaried GP based at Stone Cross Medical Centre had increased their working hours. There were plans to recruit additional partners and salaried GPs with interviews in progress.

There was an induction checklist for newly appointed staff, and we saw examples of these for nurses and managers. Locum GPs were provided with an induction pack.

Clinical staff spoken with were able to describe risk assessment and management plans carried out for patients for example, those experiencing poor mental health or prescribed high risk medicines which require monitoring. However, during our review of patient records we saw a lack of effective clinical oversight in systems to assess, monitor and manage risks to patient safety such as those with long term conditions, during medicine reviews and in the assessment of patient symptoms and potential red flags.

Staff had received training on managing a medical emergency including identifying signs and symptoms of sepsis. Staff were provided with quick reference cards for sepsis, so they were aware of how to respond. Clinicians had access to sepsis templates on the clinical system to help with the assessment process. Staff had access to equipment and medicines to deal with medical emergencies (including suspected sepsis) such as medical oxygen and a defibrillator which were regularly checked to ensure they were fit for use.

Information to deliver safe care and treatment

Staff did not have 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.	Partial
There was a system for processing information relating to new patients including the summarising of new patient notes.	Partial
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Partial
Referral letters contained specific information to allow appropriate and timely referrals.	N/A
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	N/A
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	N/A
<p>Explanation of any answers and additional evidence:</p> <p>A GP and pharmacist specialist advisor to the Care Quality Commission remotely accessed the clinical patient records system to carry out reviews of patient records, including the review of consultations. On reviewing a sample of the clinical consultation records, we found gaps and inconsistencies in the information recorded and consultations which had not been documented in line with guidance. There was overall a lack of clinical oversight. There was a lack of timely reviews and follow up and results of abnormal tests and investigation were not acted on. This meant staff did not always have the information needed to provide effective care.</p> <p>We looked at eight consultations and found that five patient records evidenced that the monitoring and review of those patients as well as the assessment, documentation and care and treatment had not been provided in line with national guidance. For example, on reviewing the records of a patient complaining of chest pain records did not include a complete relevant history or examination to fully identify or assess the severity of the patient's symptoms or determine if any red flags were present to support the assessment of care and treatment given. Searches on the clinical system identified eight patients prescribed a medicine which required monitoring in the previous six months. Three of the eight patients were identified by a search as not having had the required monitoring. A patient who was at risk of diabetes had not been referred to the diabetes prevention programme in line with national guidance.</p> <p>Since the last inspection the practice had not registered any new patients. However, we discussed the process in place to summarise a previous backlog of patient records. We were told that the provider and IT manager were leads in this area and the IT manager would run regular searches to identify any outstanding records with the practice manager maintaining oversight. The IT manager and a member of administrative staff at each practice were responsible for summarising and had received training to undertake the task. However, we were not provided any evidence of the training undertaken. The</p>	

provider told us they had cleared the previous backlog for summarising however, we were not provided assurance of how this was being monitored. On reviewing the safeguarding register we saw that a new patient had been added however, the patient did not have relevant information in their records and had not been reviewed, we also saw they had information relating to another patient in their records.

We saw evidence of multi-disciplinary team meetings where information was shared with other health care professionals such as the community matron, district nurses and health visitors. We spoke to a member of the multi-disciplinary team who provided positive feedback on the arrangements in place. However, we found gaps and inconsistencies in the information recorded in patients records in areas such as safeguarding and monitoring of high-risk medicines. This could result in other agencies not receiving accurate information to enable them to deliver safe care and treatment.

The provider discussed the arrangements in place to manage workflow. All hospital correspondences were processed by the staff including adding relevant clinical codes to the patient records. These were then forwarded to the GP to review and confirm accuracy with any errors or omissions corrected. GPs at each practice managed their work flow individually with oversight from the practice manager. The practice manager reviewed any delays, backlogs or documents requiring urgent action and these were flagged to the provider for action. However, on searching the clinical system, we saw that the system in place was not effective. There were examples of patients with a learning disability who had a care plan/annual assessment code added following receipt of hospital correspondences with no evidence of a review being completed.

Appropriate and safe use of medicines

The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) (NHS Business Service Authority - NHSBSA)	0.89	0.82	0.85	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). (01/07/2019 to 30/06/2020) (NHSBSA)	4.2%	5.9%	8.6%	Variation (positive)
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 (01/01/2020 to 30/06/2020) (NHSBSA)	5.59	5.15	5.35	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2020 to 30/06/2020) (NHSBSA)	0.81	1.35	1.92	Variation (positive)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	N/A
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial

Medicines management	Y/N/Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	N
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N/A
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	N/A
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There were arrangements in place to monitor prescriptions which included a log of prescriptions issued with a clear audit trail.</p> <p>We saw examples of current Patient Group Directions (PGD's) for childhood immunisations, However, these did not include signatures for all authorised staff.</p> <p>The provider employed a clinical pharmacist who was also an independent prescriber. However, the provider was unable to demonstrate that the clinical pharmacist completed regular reviews and assessments of their prescribing in line with national guidance.</p> <p>We did not see evidence of an effective process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. We reviewed the monitoring of patients on three Disease Modifying Anti-Rheumatic drugs (DMARDs) and seven high risk medicines that require routine monitoring due to the potential risk of harm from taking them. We identified issues with the monitoring of one DMARD medicine reviewed and two high risk medicines we reviewed. Searches on the clinical system also identified 42 patients taking a medicine which there are serious adverse risks and potential for misuse, that had not been reviewed in the previous 12 months. We reviewed the patient records of seven of these patients. Four out of the seven records we reviewed showed no evidence of these specific medicines having been reviewed. This placed patients at risk of</p>	

Medicines management	Y/N/Partial
adverse effects from taking this medicine being undetected or not identified in a timely way. On reviewing consultation records we saw a patient was prescribed medicine that in a previous letter from a specialist in secondary care services had been documented as ineffective.	

Track record on safety and lessons learned and improvements made

The practice had a system to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	Eight
Number of events that required action:	Eight
Explanation of any answers and additional evidence:	
<p>The practice used the CCG electronic reporting system to record all incidents including significant events. The system for recording, monitoring and learning from significant events had been improved since the last inspection. This including updating the local reporting template to record more detail about the incident. There was an overall local log to record all significant events and annual review meetings to identify themes and trends. There was evidence that significant events were shared in practice meetings and discussed at cross site managers meetings to share learnings across sites. Staff spoken to were aware of the system for reporting and gave examples of learning.</p>	

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

Event	Specific action taken
External contractors on site carrying out renovation left unattended with keys.	A review of the incident completed showed the time frame that contractors left unattended was minimum and no items was missing. Discussed in practice meeting and staff reminded of safety and security measures.
Patient collapsed in reception.	Staff responded appropriately, panic button pressed. GP attended to patient and stayed with patient until ambulance arrived. Patient was admitted. A review of patient records did not raise any issues that could have been foreseen. The patient contacted the surgery and thanked them for taking prompt action, the incident was taken as positive learning.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
<p data-bbox="57 407 810 443">Explanation of any answers and additional evidence:</p> <p data-bbox="57 497 1513 676">The clinical pharmacist was the practice lead responsible for Medicines Healthcare Products Regulatory Agency (MHRA) safety alerts and received these along with the practice manager. There was a central log for safety alerts as well as a local log for each practice. A paper system was also in place with a folder containing all alerts and relevant actions taken. However, we found that the lead was not receiving all safety alert updates.</p> <p data-bbox="57 730 1513 1057">Alerts were shared with staff via the electronic clinical system with an audit trail which showed when staff had accepted and actioned the alert. Safety alerts were also discussed at staff meeting and we saw examples of two alerts which were actioned appropriately. However, we found gaps in system to identify and act upon MHRA alerts. An MHRA alert issued in 2014 identified severe health risks relating to the use of a combination of medicines. We checked four patient records out of the 38 patients identified following the alert to check appropriate action had been taken. Although, we saw that all four patients had been reviewed and appropriate changes made to their medication this was only undertaken in July 2020. Delays in actioning MHRA alerts placed patients at unnecessary risk of adverse effects from medicines or health care products.</p>	

Effective

Rating: Not rated

We inspected the practice in January 2020 and rated the practice inadequate for providing effective services. The previous rating remains unchanged.

Effective needs assessment, care and treatment

Patients' needs were not always fully assessed, and care and treatment was not delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	N
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N
There were appropriate referral pathways to make sure that patients' needs were addressed.	Partial
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	N
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	N/A
<p>Explanation of any answers and additional evidence:</p> <p>Staff spoken with were aware of audits undertaken based on best practice guidance. We saw meeting minutes which took place in August 2020 that showed clinical updates such as audits and NICE guidelines were an agenda item. However, on reviewing a sample of the clinical consultation records, we found gaps and inconsistencies in the management of patients' clinical needs. For example, patients with diabetes and those on high risk medicines which require monitoring were not receiving appropriate care and treatment. We found regular reviews did not always take place, results of abnormal tests and clinical observations were not acted on in a timely manner and examples where patients had not been given advice on what to do if their condition deteriorated.</p> <p>Clinical staff spoken with told us that all urgent referrals were sent to the secretary as an urgent task and were completed the same day or the next day. The provider described the system for following up these urgent referrals which involved a note in the patient's records highlighting that the referral was urgent. Staff at each site would then follow up in two weeks to confirm the patient has received their appointment, if the patient has not received the appointment, they would contact the service.</p>	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) (NHSBSA)	0.66	0.67	0.70	No statistical variation

Older people

Population group rating: Not rated

Findings
<ul style="list-style-type: none"> The practice carried out some annual medication reviews for older patients, however on reviewing a sample of clinical records we found medication reviews were inadequate and did not follow recommended guidelines.

People with long-term conditions

Population group rating: Not rated

Findings
<ul style="list-style-type: none"> Some patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met, however we identified gaps in reviews and monitoring when reviewing a sample of patient records. Due to the lack of information recorded during consultations with patients, the practice were unable to evidence that clear and accurate information with relevant professionals was shared when deciding care delivery for patients with long-term conditions. We identified issues with the management and coding of patients at risk of developing diabetes who did not receive appropriate support and follow up.

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	60.1%	75.2%	76.6%	Variation (negative)
Exception rate (number of exceptions).	0.9% (3)	6.1%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in	42.5%	85.9%	89.4%	Significant Variation (negative)

the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>				
Exception rate (number of exceptions).	0.0% (0)	10.1%	12.7%	N/A

Indicator	Practice	CCG average	England average	England comparison
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	93.5%	91.5%	91.8%	No statistical variation
Exception rate (number of exceptions).	1.1% (1)	3.2%	4.9%	N/A

Any additional evidence or comments

The practice was significantly below the local and national average for the QOF indicator relating to patients with COPD who have had a review. The provider sent evidence in June 2020, which showed there were 81 patients on the COPD register and the date they were due a review. However, we saw that a number of these patients were overdue a review and there was no details of action to follow up these patients.

The provider sent evidence in June 2020, which showed there were 82 patients on the diabetes register and the date they were due a review. However, we saw that a number of these patients were overdue a review and there was no details of action to follow up these patient.

The provider told us that the COVID-19 pandemic had impacted on the delivery of the service and the practice was now in the process of resuming services paused during the peak of the pandemic.

The Clinical Commissioning Group's (CCG) Primary Care Commissioning Framework (PCCF) report showed the practice had failed to achieve the 2019/2020 standards for shared care prescribing, diabetes treatment targets, all coronary vascular disease and most respiratory standards. The PCCF is a scheme with eleven standards with the aim to develop general practice, encourage partnership working and deliver improvements in clinical outcome for patients.

Families, children and young people

Population group rating: Not rated

Findings

- The practice had not met the minimum 90% for one of four childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all four childhood immunisation uptake indicators.
- Since the last inspection, the practice told us they had implemented improvements to ensure all information on the safeguarding register was accurate. However, on reviewing a random sample of records we found no evidence that the practice had been proactive in reviewing or discussing the possible risks the children may be exposed to.

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) (01/04/2018 to 31/03/2019) (NHS England)	60	66	90.9%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	52	58	89.7%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	53	58	91.4%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	55	58	94.8%	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>

Working age people (including those recently retired and students)

Population group rating: Not rated

Findings

- The practice was below the national target for cervical screening. Trends over time showed the practice had consistently been low for cervical screening uptake. The practice told us that following the COVID-19 pandemic, clinics were now being implemented within practice to encourage patients to attend for screening

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	68.7%	N/A	80% Target	Below 70% uptake

to 64). (Snapshot date: 31/03/2020) (Public Health England)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	76.7%	65.6%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	53.8%	43.8%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2018 to 31/03/2019) (PHE)	57.9%	68.1%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	48.3%	48.7%	53.8%	No statistical variation

Any additional evidence or comments

The practices uptake for cervical screening was below the national screening programme target of 80%. The provider told is that the service offered at the practice had been disrupted due to COVID-19 pandemic however, patients were now able to access screening at the practice. The provider had recruited nurses at each site which they anticipated would improve access as this allowed them to increase the number of appointments available. As a result of increased nurse capacity, they were looking to set up a cervical screening clinic to help improve uptake, but this was currently at discussion stage.

People whose circumstances make them vulnerable

Population group rating: Not rated

Findings

- Searches on the clinical system identified 20 patients on the Learning Disability register. We reviewed four out of the 20 patients and found three out of the four patients reviewed did not have an up to date care plan or assessment. We also found safeguarding arrangements for the recording, monitoring and management of vulnerable adults was not adequate and kept up to date.
- There was a lack of a systematic structured approach in the delivery of care and treatment and the quality assurance system and clinical oversight was not effective. The concerns identified impacted all of the population groups including this group.
- The practice carers register listed 70 patients. The Clinical Commissioning Group's (CCG) Primary Care Commissioning Framework (PCCF) report showed the practice had failed to achieve the 2019/2020 standards for carers offered health checks in last 12 months.

People experiencing poor mental health (including people with dementia)

Population group rating: Not rated

Findings

- The practice had a significant negative variation for QOF mental health indicators. The Clinical Commissioning Group's (CCG) Primary Care Commissioning Framework (PCCF) report also showed the practice had failed to achieve the 2019/2020 standards for mental health indicators.
- Nationally reported patient outcome data showed the practice performance for mental health and dementia indicators was significantly below local and national averages.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	33.3%	84.1%	85.4%	Significant Variation (negative)
Exception rate (number of exceptions).	3.2% (1)	20.2%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	26.1%	79.0%	81.4%	Significant Variation (negative)
Exception rate (number of exceptions).	8.0% (2)	9.0%	8.0%	N/A

Monitoring care and treatment

The practice had a programme of quality improvement activity. However, this was not comprehensive with limited monitoring of the outcomes of care and treatment.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	492.1	536.8	539.2
Overall QOF score (as a percentage of maximum)	88.0%	96.1%	96.7%
Overall QOF exception reporting (all domains)	2.5%	6.7%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Partial
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Partial
Quality improvement activity was targeted at the areas where there were concerns.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	N/A

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

<p>The practice provided the following two examples of clinical audits completed.</p> <ol style="list-style-type: none"> 1. Non-steroidal anti-inflammatory drugs (NSAID) and proton-pump inhibitors (PPI) audit completed at each site. The aim of the audit was to reduce the risk of gastrointestinal adverse events and
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hospital admissions on patients on long term NSAIDs and no gastroprotection. A baseline audit at the practice on 13 June 2020 found 11 out of 27 patients on long term NSAIDs without gastroprotection. These patients were contacted and reviewed and on 18 June 2020 the number of patients on long term NSAIDs without gastroprotection was reduced to five. The plan was to continue to monitor.

2. Audit of patients using a continuous glucose monitoring system (Freestyle Libre Flash Glucose Sensor) following MHRA alert which reported some patients experiencing skin reactions and that using barrier creams may affect performance of the device. The audit also checked blood glucose control with the system and any hypoglycemic hospital admissions due to malfunctioning of the sensor. A baseline audit was completed on 13 June 2020 which identified six patients using the system. A second audit was completed on 18 June 2020. After reviewing, five patients reported improved blood glucose control and one had reported skin reactions and had used barrier cream. None had been hospitalised with hypoglycemia while on the system. The audit stated that those with skin reaction were to be switched to an alternative glucose monitoring system by contacting the local diabetes team or referral. However, it was not clear if this was done.

The limited time frame between the audits did not provide sufficient time for changes to be fully embedded and reviewed. The provider had no formal audit programme planned for the year ahead but told us that they would be discussing these with the newly appointed GP partner and other staff at the next clinical meeting.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles. However, some areas lacked clinical oversight.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Partial
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial

There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a system in place to monitor and record training for staff including those newly appointed. A training matrix was in place which showed the mandatory training requirements. The practice manager had oversight of training and reported directly to the executive manager. Staff received email notifications as reminders of training due and given protected time to complete training. Staff spoken with gave examples of training that they were interested in and were supported to pursue. There were regular clinical meetings which were chaired by the clinical leads and provided an opportunity for learning and development, we saw minutes of a clinical meeting held in August 2020. There was evidence that staff had completed training in areas such as infection prevention and control, basic life support and fire safety. Newly appointed staff such as GP's, clinical pharmacist and nurses had received an induction.</p> <p>The practice manager who was recently appointed along with managers across other sites initially had weekly meetings with the provider/lead GP and the executive manager, these were later reduced to two weekly. There was evidence that the manager had received a three-monthly progress meeting with another schedule at the six-monthly stage. A formal call took place at the end of the working day to provide the practice manager the opportunity to discuss any issues with the executive manager and lead GP/provider.</p> <p>We saw some arrangements in place for the supervision and appraisal of staff. However, on reviewing a sample of clinical supervision sessions we found these to be minimal. We were told that the clinical leads were in place to support clinical supervision and GPs were given 10 minutes at the end of each day for peer support. On reviewing a sample of clinical records we identified a lack of clear oversight of care and treatment provided.</p>	

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A
Explanation of any answers and additional evidence: We saw evidence of multi-disciplinary team meetings where information was shared with other health care professionals such as the community matron, district nurses and health visitors.	

Well-led

Rating: Not rated

We inspected the practice in January 2020 and rated the practice inadequate for providing well led services. The previous rating remains unchanged.

Leadership capacity and capability

Leaders could demonstrate that they had the capacity to deliver high quality sustainable care. However, there was a lack of effective clinical leadership oversight.

	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.	Y
There was a leadership development programme, including a succession plan.	Partial
Explanation of any answers and additional evidence: The provider understood the challenges they faced and was trying to address them which included changes to the organisation structure to help improve clinical and governance oversight. The leadership team which included the provider and executive manager was strengthened by appointing a GP partner and practice managers at each site. There were clinical leads for each site who took lead roles for areas such as diabetes, safeguarding and medicine management and worked closely with the lead GP and practice manager. There was also a named senior receptionist at each site. This was reflected in areas of improvements such as health and safety, recruitment processes, infection prevention and control and training. However, there was a lack of clinical oversight and the absence of comprehensive systems and processes to monitor the quality and effectiveness of the service and the care provided. This was identified by gaps and inconsistencies in patients care and treatment. The provider shared some of the challenges faced as a result of the COVID-19 pandemic and the impact of this. However, the use of technology and working collaboratively with the CCG and Primary Care Network (PCN) had enabled them to adapt the approach to the delivery of the service. In response to findings of the last inspection, the CCG had commissioned support for the provider for all three sites from the Royal College of General Practitioners (RCGP). Based on findings the RCGP produced a report in April 2020 highlighting areas for improvement. An action plan was produced for the provider to take forward and we saw evidence of areas of progress such as governance oversight however, other areas required ongoing improvement.	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Partial
There was a realistic strategy to achieve their priorities.	Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N/A
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The leadership team shared the vision and values which was to provide the best care for patients and modify services to meet the needs in a rapidly changing environment for example, by using technology to help centralise functions. This was aligned with what staff told us. However, at the time of the inspection there were gaps and inconsistencies in the care and treatment received by patients due to a lack of effective systems and processes to ensure the vision and values were monitored and delivered consistently.</p>	

Culture

The practice had a culture to support high quality sustainable care

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	N/A
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y

The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff told us they felt supported by the leadership team and felt confident to raise any issues or concerns and would be listened to. We saw team meetings, huddles and appraisals took place which provided an opportunity for learning and development and for staff to raise any issues. The practice had a whistleblowing policy which was site specific, a designated Freedom to Speak Up Guardian and an allocated number for staff to call should they wish to raise any concerns.</p> <p>Complaints reviewed demonstrated that when people were affected by things that went wrong, they were given an apology.</p>	

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

Source	Feedback
Staff Members	Staff were positive about the new organisational structure and leadership team. Staff reported leaders were approachable, accessible and supportive of learning and development opportunities. Staff told us that the leaders were responsive to ideas and suggestions for improvement.

Governance arrangements

There were some improvements to the overall governance arrangements however, processes and systems in place to support the delivery of good quality and sustainable care were not fully embedded.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>There were positive changes in the governance arrangements since the previous inspection. This was demonstrated by an increase in leadership capacity and improvements in local systems and processes. For example, clinical and non-clinical leads at each site, regular practice and clinical meetings, staff appraisals and training opportunities.</p> <p>The lead GP and the new GP partner attended the practice meetings on each site. However, there were informal arrangements for information sharing and discussions across sites with little centralised functions to ensure a consistent approach in the monitoring of the quality and safety. This was demonstrated in gaps, inconsistencies in systems and processes such as the management of patients care and treatment, safeguarding and supervision arrangements for clinical staff.</p>	

The provider told us of plans to develop more central structures using technology and practice managers at each site providing feedback to the provider and executive manager to help maintain corporate oversight.

Managing risks, issues and performance

There were gaps in the system and processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	Partial
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Partial
Explanation of any answers and additional evidence:	
There were improvements to the processes to demonstrate quality assurance. For example, we saw risk assessments for health and safety and fire safety and audits had been completed in areas such as infection prevention and control and medicine management. The systems and processes to manage recruitment and training had been improved. There were meetings in place for staff where standard agenda items included complaints and significant events which were discussed and reviewed on an annual basis. Our discussion with staff demonstrated they were aware of what to do in the event of a major incident. However, assurance systems in place did not proactively identify and manage all risks. For example, gaps and inconsistencies were found in the management of patients care and treatment and in the safeguarding processes. These areas had been identified at the previous inspections with conditions imposed.	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	N/A
Explanation of any answers and additional evidence:	

There was an IT manager who worked across all sites supporting staff with data inputting. The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The most recently available QOF data for this practice showed the overall QOF score for the practice was lower than the national average with areas requiring improvements such as cervical screening and diabetes. This was aligned with gaps and inconsistencies we found on reviewing clinical records with the care and treatment of patients with diabetes.

The arrangements for identifying, managing and mitigating risks were not always effective in areas such as the management of patients care, and treatment and safeguarding processes.

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	N/A
Patient records were held in line with guidance and requirements.	N/A
Any unusual access was identified and followed up.	N/A
Explanation of any answers and additional evidence:	

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.	Partial
The practice had an active Patient Participation Group.	Partial
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<p>The most recent national GP patient survey data for the period January 2020 to March 2020, showed the practice was similar to the local but below the national average in questions relating to people's experience of a caring service. Questions aligned with accessing the service were below local and national averages, although there was overall improvement from previous years.</p> <p>The practice had taken some action to improve access by installing a new telephone system in June 2020, which enabled call recording, monitoring and had a call waiting system. This allowed for auditing of call waiting and response times. An in-house patient questionnaire had been completed in August 2020 in response to the results of the national GP survey. A total of 14 patients had responded and data had been collated and reviewed. The feedback was generally positive, with patient's ability to get through by phone identified as an area for improvement. The practice anticipated the installation of the new</p>	

telephone system would have a positive impact on results in the upcoming months. There were plans to use more digital solutions to improve access such as a GP App.

The practice obtained feedback from comments and complaints to help improve the service. There was a complaints policy and information on how to complain was available on the practice website. A complaints leaflet and form was available from the practice. We saw the practice had received 11 complaints between January 2020 and September 2020. We reviewed two complaints and found they had been responded to appropriately and in a timely manner. Complaints were discussed in the practice meetings as a standing agenda item and discussed in cross site managers meetings to review any trends and to share learning. There was also an annual review of complaints to maintain oversight of any themes and trends.

The practice had a Patient Participation Group (PPG) to help improve patient engagement and feedback, with meetings attended by the provider. However, meetings had been paused due to COVID-19. The practice manager had contacted members of the PPG on commencing their post and was arranging a virtual meeting with members.

The provider was engaging with stakeholders and other agencies to develop quality assurance systems and improve the delivery of the service. During the peak of the COVID-19 pandemic the practice worked within the PCN and CCG to deliver services safely. They had also engaged with NHS England, the Local medical Committee, the RCGP and the CCG to improve services.

The CCG had commissioned support for the provider from the RCGP who reported on the findings and identified actions for the provider to take forward. Staff were offered online training courses from the CCG to support training and development. The practice also worked with members of the multi-disciplinary team to deliver services.

Feedback from Patient Participation Group.

Feedback

N/A

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence:	
There was some evidence of continuous learning and improvement. This was demonstrated by staff training, appraisals and meetings where complaints, significant events and best practice guidelines were shared and discussed. We saw evidence of clinical and non-clinical audits completed such as infection prevention and control and patient feedback questionnaires.	
In response to COVID-19 the practice had worked in collaboration with the PCN and CCG to implement digital services such as online consultations and video consultations. However, there were	

gaps and inconsistencies in systems and processes for learning and improvement. This included a lack of clinical and governance oversight in patients care and treatment.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

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

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

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

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

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

Glossary of terms used in the data.

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