Care Quality Commission

Inspection Evidence Table

Nuffield Road Medical Centre (1-548229142)

Inspection date: 7 August 2019

Date of data download: 01 August 2019

Overall rating: Requires Improvement

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Safe Rating: Requires Improvement

At this inspection, the practice was rated as requires improvement for providing safe services because:

- The practice's system of recruitment checks was not fully effective. We found one clinical member of staff did not have a DBS check completed. In addition to this, the practice was unable to provide evidence of the immunisation status of staff.
- We found the practice did not have an effective fire risk assessment completed; we identified fire risks which had not been recorded in the fire risk assessment completed one week before our inspection.
- Concerns highlighted in an external health and safety risk assessment completed in July 2019 had not been identified during the fire risk assessment and no actions had been completed.
- The practice did not provide evidence to show equipment had been calibrated.
- No infection prevention and control audit had been completed in the practice since 2017. We found some areas of concern; for example, a sharps waste bins left on a consultation room floor and paint and plaster coming away from the walls in one treatment room.
- The practice did not have a system in place for managing the security of prescription papers.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial[1]
Staff who acted as chaperones were trained for their role.	Partial[2]
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[3]

Explanation of any answers and additional evidence:

1 – The practice told us that all staff received a DBS check prior to commencing employment. However, we found one clinical member of staff had not received a DBS check. The practice told us following the inspection this check had been applied for.

2 – On the day of the inspection we asked which members of staff were trained chaperones. At the time, the practice were unable to produce a list of chaperones and were unsure who was trained for the role. Following the inspection, the practice provided clarity on the chaperones and their training.

3 – We reviewed safeguarding meeting minutes and found them to lack sufficient detail. We found that on some occasions, discussions were only documented by one or two key words which did not fully explain the situation or enable others the concerns to be shared. The practice told us safeguarding information was documented on individual care records.

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.	N[1]
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: 1 – On the day of the inspection we asked to review the immunisation status of staff. The practice was unable to provide a complete list of immunisation status for clinical staff and personnel files did not contain the information.	

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: January 2019	Y
There was a record of equipment calibration. Date of last calibration: See [1] below.	N[1]
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: June 2019	Y
There was a log of fire drills. Date of last drill: 25 July 2019	Y
There was a record of fire alarm checks. Date of last check: Weekly checks were completed by the practice.	Y
There was a record of fire training for staff. Date of last training: On-going training as per individual staff requirements	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: August 2019	Partial[2]
Actions from fire risk assessment were identified and completed.	N[2]
Explanation of any answers and additional evidence: 1 – The calibration of equipment was unclear; the practice provided us with a notepad on the day of the inspection containing details of some equipment being sent for calibration. This notepad was not a complete list of all equipment in the practice and often did not include dates the equipment was returned. Following the inspection, the practice told us they had made improvements to the system for equipment calibration. 2 – A fire risk assessment had been completed by the practice manager one week prior to our inspection. We found areas of concern such as no oxygen signage on doors where oxygen was stored.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: July 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: July 2019	N[1]
Explanation of any answers and additional evidence: 1 – Concerns highlighted in an external health and safety risk assessment completed in July 2019 had not been identified during the fire risk assessment and no actions had been completed.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: June 2017	Partial[1]
The practice had acted on any issues identified in infection prevention and control audits.	N[1]
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.	N[2]

Explanation of any answers and additional evidence:

1 – The practice told us the last infection prevention and control audit was completed in 2017. We found areas of infection prevention and control concern such as a sharps waste bins left on a consultation room floor and paint and plaster coming away from the walls in one treatment room. The practice told us they intended to complete an infection prevention and control audit following the inspection.

2 – We found a sharps waste bin left on a consultation room floor and other sharps waste left on the floor in an unlocked sluice room. When we raised this with the practice on the day of the inspection, the practice removed the sharps waste from the floors and ensured all staff areas remained locked.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
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

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y[1]
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
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.	Y
Explanation of any answers and additional evidence: 1 – On the day of the inspection we found test results were generally well managed. However, we found one outstanding test result from 22 June 2019 which had not been actioned despite a positive result. When we raised this with the practice, they advised they would take immediate action and speak to the clinician involved.	

Appropriate and safe use of medicines

The practice had some 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) (01/04/2018 to 31/03/2019) (NHS Business Service Authority - NHSBSA)	0.99	0.94	0.88	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). (01/04/2018 to 31/03/2019) (NHSBSA)	14.0%	11.3%	8.7%	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 (01/10/2018 to 31/03/2019) (NHSBSA)	6.20	5.86	5.61	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) (NHSBSA)	1.96	2.08	2.07	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	N[1]
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N/A
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
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[2]
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[3]
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y[4]
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

Explanation of any answers and additional evidence:

1 – We found the practice did not have a system in place for managing blank prescription papers. We were told the consultation rooms in the building remained unlocked during the day and at night. The blank prescription paperwork remained in the printers in the consultation rooms and there was no system for recording batch numbers. Following the inspection, the practice told us they had taken action to lock all consultations rooms when not in use and a system for recording batch numbers had been implemented.

Medicines management	Y/N/Partial
2 – The practice was aware of their higher than CCG and England average prescribing of antimicrobial items. The practice conducted an annual audit of clinical services which reviewed the appropriateness of the prescribing. The practice told us they spoke to individual clinicians where appropriate. The practice told us the prescribing rate had reduced from the data contained within the report. 3 – We found emergency medicines, equipment and vaccines were stored in an unlocked sluice room. When we raised this with the practice on the day of the inspection, the practice told us they would ensure all staff areas remained locked. 4 – We found the medical oxygen was stored in a sluice room, this room did not have appropriate signage on the door to warn of the storage of oxygen. The practice told us they would erect appropriate signage following the inspection.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y[1]
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:	32 Apr 19 – inspection
Number of events that required action:	32
Explanation of any answers and additional evidence: 1 – The practice acknowledged they recorded a high number of significant events. The practice encouraged reporting of all events by staff, including near misses and learning opportunities. The significant event process allowed for the practice team to learn from events and we saw evidence to show events were discussed during practice meetings.	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
A patient's referral was missed and not correctly submitted.	The patient was contacted and apologised to. The referral was immediately made once the error was identified and learning was distributed amongst staff.
The building was left unsecured during the weekend.	The practice contacted the extended hours service to notify them of the incident and request an investigation.

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

Effective Rating: Requires Improvement

At this inspection, the practice was rated as good for providing effective services to older people and vulnerable people. The practice was rated as requires improvement for providing effective services to people with long-term conditions, families, children and young people, working aged people (including those recently retired and students) and people with poor mental health (including people with dementia) and therefore overall because:

- The practice's Quality and Outcomes Framework performance for long-term conditions and mental health was lower than the CCG and England averages. We reviewed submitted but unverified 2018/2019 data and found this performance had continued.
- The practice's childhood immunisation uptake rate was lower than the 90% target rate and no action had been taken to improve this.
- The practice's cervical screening uptake rate was lower than the 80% target rate and no action had been taken to improve this.
- The practice did not target quality improvement activity to areas of poor performance.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial[1]
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial[1]
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence: 1 – We found patients' treatment was generally reviewed and updated, however, the practice's performance of long-term conditions reviews was lower than the CCG and England averages.	

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) (01/04/2018 to 31/03/2019) (NHSBSA)	1.08	0.82	0.77	No statistical variation

Older people — Population group rating: Good

Findings
• The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. • The practice completed an annual report which included a review of frailty assessments. From this, we found 99% of severe frailty patients had a medicine review in the previous 12 months and 72% of severe frailty patients had a co-ordinated care plan in place. • The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. • The practice carried out structured annual medication reviews for older patients. • The practice carried out regular visits to nursing and residential homes. In addition to this, as part of the practice's annual report, the practice reviewed the number of medicine reviews completed, the number of end of life care plans in place and the number of patients who died in their preferred place of death, • Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. • Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- 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.
- The practice's Quality Outcomes Framework performance for long-term condition indicators such as; diabetes, asthma, COPD and hypertension, were below the CCG and England averages. We reviewed submitted but unverified data for 2018/2019 and found this level of performance had continued.
- 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 atrial fibrillation were assessed for stroke risk and treated appropriately.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	79.0%	80.5%	78.8%	No statistical variation
Exception rate (number of exceptions).	11.3% (76)	15.7%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	69.3%	74.4%	77.7%	No statistical variation
Exception rate (number of exceptions).	8.1% (54)	11.9%	9.8%	N/A
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	68.0%	79.3%	80.1%	Variation (negative)
Exception rate (number of exceptions).	15.5% (104)	15.5%	13.5%	N/A

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, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	62.2%	76.2%	76.0%	Variation (negative)
Exception rate (number of exceptions).	13.4% (131)	7.9%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	73.8%	90.8%	89.7%	Variation (negative)
Exception rate (number of exceptions).	13.5% (38)	13.2%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	75.8%	82.2%	82.6%	Tending towards variation (negative)
Exception rate (number of exceptions).	3.4% (56)	4.7%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	94.5%	90.8%	90.0%	No statistical variation
Exception rate (number of exceptions).	18.0% (40)	7.6%	6.7%	N/A

Any additional evidence or comments
• The practice had a higher exception reporting rate for some long term conditions. The practice were aware of this and told us they only excepted patients in line with guidance and actively followed up patients with asthma who did not attend. However, the practice had no additional plans in place at the time of the inspection to try and reduce the number of exceptions who did not attend. We reviewed some examples of exception reporting and found them to be in line with relevant guidance.

Families, children and young people

Population group rating: Requires Improvement

Findings

- Childhood immunisation uptake rates were below the World Health Organisation (WHO) target rate of 90% with a range of 80.6% and 88.3%.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

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)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	144	163	88.3%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	143	175	81.7%	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) (01/04/2017 to 31/03/2018) (NHS England)	141	175	80.6%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	142	175	81.1%	Below 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information:
https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices

Any additional evidence or comments

- The practice had a lower uptake rate for childhood immunisations than the 90% World Health Organisation target. The practice were aware of this; however, the practice had no plans in place at the time of inspection to try to improve this rate.

  The practice believed this lower uptake rate was in part due to the significant number of travelling community children registered with the service. However, the practice had not attempted to engage or educate the population to improve the uptake. The practice told us they held quarterly meetings with the Council Traveller Nurse to engage with their higher than average proportion of patients who are Travellers.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. In the previous 12 months, 1,409 health checks were offered and 26% of those were completed.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	62.4%	70.9%	71.7%	Tending towards variation (negative)
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) **(PHE)**	65.6%	73.4%	69.9%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) **(PHE)**	55.0%	56.9%	54.4%	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. (01/04/2017 to 31/03/2018) **(PHE)**	84.4%	63.0%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	60.8%	60.6%	51.9%	No statistical variation

Any additional evidence or comments
• The practice had a lower uptake rate for cervical screening than the 80% Public Health England target. The practice were aware of this; however, the practice had no plans in place at the time of inspection to try to improve this rate. The practice believed this lower uptake rate was in part due to the significant number of Travellers registered with the service. However, the practice had not attempted to engage or support the population to improve the uptake. The practice told us they held quarterly meetings with the Council Traveller Nurse to engage with their higher than average proportion of patients who are Travellers.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check. In the previous 12 months, 31 (35%) health checks had been completed for 89 eligible patients.
- 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.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

- The practice's Quality Outcomes Framework performance for mental health indicators were below the CCG and England averages. We reviewed submitted but unverified data for 2018/2019 and found this level of performance had continued.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

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 (01/04/2017 to 31/03/2018) (QOF)	63.7%	91.0%	89.5%	Significant Variation (negative)
Exception rate (number of exceptions).	15.1% (22)	13.2%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	63.8%	89.7%	90.0%	Significant Variation (negative)
Exception rate (number of exceptions).	11.0% (16)	11.8%	10.5%	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 (01/04/2017 to 31/03/2018) (QOF)	78.5%	85.0%	83.0%	No statistical variation
Exception rate (number of exceptions).	3.9% (11)	6.6%	6.6%	N/A

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	524.2	543.0	537.5
Overall QOF score (as a percentage of maximum)	93.8%	97.1%	96.2%
Overall QOF exception reporting (all domains)	8.5%	6.5%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y[1]
Quality improvement activity was targeted at the areas where there were concerns.	Partial[2]
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

Any additional evidence or comments

1 – The practice completed an annual report which reviewed a number of clinical areas:

- Quality Outcomes Framework (QOF) data
- Practice audits
- Childhood immunisations
- Medicine monitoring
- Enhanced services
- Prescribing
- Minor surgery
- Residential and nursing homes
- Frailty assessments
- Health checks

This report had been completed annually for a number of years and allowed the practice to monitor performance and review against previous years. The practice could analyse trends and use the information to assess staffing levels, competencies and performance.

2 – We found areas of concern on the inspection which had been identified in the practice's annual report, such as cervical screening uptake, childhood immunisation uptake and QOF performance. We found no actions had been taken to make improvements based upon the issues identified in the internal report.

Effective staffing

The practice was unable 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. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
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.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial[1]
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[1]
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

1 – Some members of staff told us they had received an appraisal in the previous 12 months; however, the new practice manager was unable to produce any documented evidence of staff appraisals and told us they were aware of the shortfalls of this system due to a change in practice management and had plans to improve it. Following the inspection, the practice told us improvements had been made to the staff appraisal systems.

2 – The practice had an informal system of supporting staff employed in advanced clinical practice. The practice told us staff were supported by the duty GP on a daily basis with any concerns they may have. Consultations would be reviewed and support offered where appropriate.

Coordinating care and treatment

Staff worked did not work together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
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.	Y

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Partial[1]
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
Explanation of any answers and additional evidence: 1 – The practice offered health checks to eligible patients, however we found that the uptake of the health checks was low in some areas, in the previous 12 months: • 1,409 40-74 health checks offered, 26% were completed. • 89 eligible patients diagnosed with a learning disability, 35% completed.	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	93.5%	95.3%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.5% (15)	0.9%	0.8%	N/A

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y

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.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

CQC comments cards	
Total comments cards received.	27
Number of CQC comments received which were positive about the service.	27
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC patient comment cards	We received 27 CQC comment cards from patients on the day of the inspection. All comment cards contained positive feedback in relation to the practice, including a number of cards which commented on the kindness of staff and how well staff treated patients.
Patient consultations	Patients we spoke with on the day of the inspection were positive about the caring attitude displayed by staff. Patients we spoke with told us they were happy to be registered at the practice.
NHS Choices	Feedback from patients on NHS Choices was mixed; with two stars from 22 reviews. The reviews contained mixed feedback in relation to the attitude of staff.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
14310	326	105	32.2%	0.73%

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 (01/01/2019 to 31/03/2019)	83.3%	89.9%	88.9%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	79.5%	87.9%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	93.7%	95.7%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	73.0%	84.3%	82.9%	No statistical variation

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

Source	Feedback
CQC patient comment cards	We received 27 CQC comment cards from patients on the day of the inspection. All comment cards contained positive feedback in relation to the practice, including a number of cards which commented on specific incidents where they felt involved in decisions about their care and treatment.
Patient consultations	Patients we spoke with on the day of the inspection were positive about how patients were involved in decisions about care and treatment.
NHS Choices	Feedback from patients on NHS Choices was mixed; with two stars from 22 reviews. The reviews contained mixed feedback in relation to patients being involved in decisions about their care and treatment.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	95.6%	93.8%	93.4%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	The practice had identified and supported 288 carers, approximately 2% of the practice population.
How the practice supported carers (including young carers).	The practice offered health checks and flu vaccinations to patients identified as a carer; in addition to opportunistic signposting to relevant support groups and organisations. We saw evidence of carer support literature throughout the practice.
How the practice supported recently bereaved patients.	The practice advised the practice would contact recently bereaved patients to offer their condolences, support and an appointment where necessary.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8.30am to 6pm
Tuesday	8.30am to 6pm
Wednesday	8.30am to 6pm
Thursday	8.30am to 6pm
Friday	8.30am to 6pm
Appointments available:	
Monday	8.30am to 6pm
Tuesday	8.30am to 6pm
Wednesday	8.30am to 6pm
Thursday	8.30am to 6pm
Friday	8.30am to 6pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
14310	326	105	32.2%	0.73%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019)	90.9%	93.9%	94.5%	No statistical variation

Older people — Population group rating: Good

Findings

- All 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 urgent appointments for those with enhanced needs and complex medical issues.
- The practice employed an Emergency Care Practitioner who offered home visits for those with enhanced needs and complex medical issues.
- The practice completed regular visits to nursing and residential homes.
- The practice provided effective care coordination to enable older patients to access appropriate services.

People with long-term conditions — Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- The practice offered home visits to conduct reviews of long-term conditions for patients with enhanced needs and complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people — Population group rating: Good

Findings

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students) — Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice offered pre-bookable routine evening and weekend appointments to all patients at additional locations within the area, as the practice was a member of a GP federation.
- Telephone appointments were available to patients who were unable to attend the practice in person.

People whose circumstances make them vulnerable — Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a high proportion of travelling community patients, approximately 5% of the practice population. The practice told us they held quarterly meetings with the Council Traveller Nurse to engage with their higher than average proportion of patients who are Travellers.
- 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 provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings
• Priority appointments were allocated when necessary to those experiencing poor mental health. • Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. • The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

People were able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y

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 (01/01/2019 to 31/03/2019)	63.4%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	57.1%	72.6%	67.4%	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 (01/01/2019 to 31/03/2019)	58.8%	66.9%	64.7%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	70.9%	78.3%	73.6%	No statistical variation

Any additional evidence or comments
• The practice were aware of lower than average National GP Patient Survey data in comparison to CCG and England averages for access indicators. The practice had implemented a 'Doctor First' triaging system in an attempt to improve patient satisfaction. In addition to this, the practice had employed emergency care practitioners, a clinical pharmacist and provided additional training to nursing staff and health care assistants in order to improve patient access. The practice told us they intended to review the newly implemented services and patient satisfaction following the inspection.

Source	Feedback
CQC patient comment cards	We received 27 CQC comment cards from patients on the day of the inspection. All comment cards contained positive feedback in relation to the practice.
Patient consultations	Patients we spoke with on the day of the inspection provided mixed feedback about accessing the practice. Some patients advised they had no difficulties, whereas other patients told us they sometimes had difficulties accessing the practice by telephone and accessing appointments.
NHS Choices	Feedback from patients on NHS Choices was mixed; with two stars from 22 reviews. The reviews contained mixed feedback in relation to patients being able to access care and treatment.

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.	5 April 19 - inspection
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Examples of learning from complaints.

Complaint	Specific action taken
Complaint regarding accessing appointments	The practice contacted the patient to apologise, the practice were planning to carry out an analysis of capacity and this complaint was involved in that process.
Patient concerned multiple tests required due to practice incorrectly submitting.	The patient was contacted, apologised to and reassurance given regarding the test results. Learning distributed to staff.

Well-led Rating: Requires Improvement

At this inspection, the practice was rated as requires improvement for providing well-led services because:

- We found the practice did not always have governance structures and systems in place, and where they were in place, these were not always effective.
- We found that despite the practice identifying a number of risks and performance issues through their internal audit process, these were not always monitored and actions had not been taken.
- The practice did not have documented records to confirm staff received an annual appraisal, supervision or competency checks. Some staff confirmed they had received an appraisal and had on-going supervision but this was not recorded.

Leadership capacity and capability

There was compassionate and inclusive and leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	N[1]
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: 1 – We found that leaders demonstrated an awareness of the challenges to quality and sustainability. We found that despite the practice identifying a number of risks and performance issues through their internal audit process, these were not always monitored and actions had not been taken.	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	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.	Y
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

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

Source	Feedback
Staff consultations	Members of staff we spoke with during the inspection told us they were happy to work at the practice and felt well supported by the practice leadership team. Members of staff acknowledged at times the working environment was difficult due to circumstances beyond their control; but felt happy with the roles they undertook at the practice.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N[1]
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: 1 – We found the practice did not always have governance structures and systems in place, and where they were in place, these were not always effective. For example, we found the practice did not have a system to manage the security of prescription paperwork and an infection prevention and control audit had not been undertaken since 2017. In addition to this, recruitment systems in place were not always fully effective as we found one clinical member of staff employed without a DBS check.	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial[1]
There were processes to manage performance.	Partial[2]
There was a systematic programme of clinical and internal audit.	Y[1]
There were effective arrangements for identifying, managing and mitigating risks.	N[1]
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y

Explanation of any answers and additional evidence:

1 - The practice completed an annual report which reviewed a number of clinical areas. This report had been completed annually for a number of years and allowed the practice to monitor performance and review against previous years. However, we found areas of concern on the inspection which had been identified in the practice's annual report, such as cervical screening uptake, childhood immunisation uptake and QOF performance. We found that no actions had been taken to make improvements based upon the issues identified in the internal report. However, the practice told us they felt they had started to address issues raised in the report by training nurses and health care assistants in mental health and diabetes reviews and the pharmacist in rheumatoid arthritis and epilepsy reviews.

2 – Some members of staff told us they had received an appraisal in the previous 12 months; however, the new practice manager was unable to produce any documented evidence of staff appraisals and told us they were aware of the shortfalls of this system due to a change in practice management and had plans to improve it. The practice had an informal system of supporting staff employed in advanced clinical practice. The practice told us staff were supported by the duty GP on a daily basis with any concerns they may have. Consultations would be reviewed and support offered where appropriate. However, this system was not recorded formally. Following the inspection, the practice told us improvements had been made to the staff appraisal systems.

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Engagement with patients, the public, staff and external partners

The practice did not always involve the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial[1]
The practice had an active Patient Participation Group.	N[1]
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: 1 – The practice did not have an active Patient Participation Group at the time of the inspection and the practice was unable to demonstrate how it engaged with patients. Whilst the practice had taken action to improve patient satisfaction for accessing the practice, this had not been monitored or assessed to gage any improvements to patient satisfaction.	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial[1]
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: 1 –Where actions had been identified as being required, the practice could not always evidence these actions had been implemented. In addition to this, the practice did not have an effective appraisal and supervision process in place and could not evidence that all staff received appropriate support.	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- 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.

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

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.