Care Quality Commission

Inspection Evidence Table

Coatham Surgery (1-574136306)

Inspection date: 6 and 7 September 2021

Date of data download: 09 August 2021

Overall rating: Requires Improvement

In February 2020 we rated the practice as Requires Improvement overall because there were areas of safety, effectiveness and responsiveness that needed to be improved. Although the provider addressed some of our findings in these areas since that inspection, at this September 2021 inspection we saw that safety, effectiveness and responsiveness and leadership still needed to be improved. **We have again rated the practice as Requires Improvement overall.**

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

Safe Rating: Inadequate

At our February 2020 inspection we rated the practice as Requires Improvement because the arrangements for medication reviews and clinical correspondence needed improving. Prescribing trends were below average. At this September 2021 inspection we found concerns relating to; Systems, processes and records kept around Do Not Attempt Cardiopulminory Resuscitation (DNACPR) decisions, recruitment files, the management of test results, monitoring of high-risk medicines, processes for safety alerts and medicines' management. **We have rated the practice as inadequate for providing safe services.**

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 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

Safeguarding	Y/N/Partial
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were 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
Explanation of any answers and additional evidence:	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	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: We sampled four recruitment files during our inspection. All four did not contain photographic proof of identification, only one out of four contained employment references, and only two out of four contained employment history. This was contrary to Schedule 3 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.	

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: 29 June 2021	Y
There was a record of equipment calibration. Date of last calibration: 19 August 2021	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
A fire risk assessment had been completed. Date of completion: 17.05.2021 (extinguishers' inspection)	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out.	Y

Date of last assessment: various dates throughout previous 12 months	
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 22.06.2021	Y
Explanation of any answers and additional evidence:	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were 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: 22 March 2021	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
Explanation of any answers and additional evidence: The infection control lead nurse had recently left the practice, so a GP was temporarily acting as the lead for an interim period. During our inspection we saw that staff were adhering to Covid-19 guidance for health care settings.	

Risks to patients

There were some 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.	Partial
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
Explanation of any answers and additional evidence: The induction pack was limited in its scope and did not effectively demonstrate the readiness of new starters, once completed.	

Information to deliver safe care and treatment

Staff did not always 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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Partial
There was a documented approach to the management of test results, and this was managed in a timely manner.	N
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N

Explanation of any answers and additional evidence:

The practice had coded 49 patients as having a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision in place. We looked at five of these records, at random, during our inspection. In all five records we saw that there was no information or detail behind the decision making, or indication that the patient had understood the implications of the decision. There was an absence of recording that the patients had met the test for capacity to make the decision. It was unclear how the process for reviewing this annually was being carried out consistently. There was no recording of what a patient should do if they changed their mind about the DNACPR decision. It was not evident that such decisions had been made in consultation with the patient. This presented a risk to the safety of these patients.

The system for referrals relied on a clinician's memory to check that these had been made. There was no mechanism in place to know if a referral had not been processed. We saw two examples of missed referrals on the practice's significant event log, but the patients had not come to harm because of it. The referrals were subsequently made by the practice.

We saw evidence from patient records of abnormal test results that had been filed as normal. There was a recurring theme within the significant events log of misinterpretation of test results. The provider delivered a clinical update to the clinical team, regarding the interpretation of test results in March 2021, and we saw that no further adverse events relating to this had been logged after that session.

We were not assured that repeat prescriptions had been signed and issued with timely oversight of the most recent test results. Some clinicians could describe the process for this, but the system did not appear to be functioning effectively.

Meeting minutes described the provider's own concerns that clinicians were frequently forgetting to 'flag' tasks (particularly when filing bloods) resulting in delays in care, and that the quality of information within tasks was often limited or unclear.

However, on the day of our inspection, there appeared to be no delays in the management of test results. We saw that 46 test results were awaiting filing on the day of our inspection, the oldest of these was from seven days prior.

There were five documented incidents of results being misread or misinterpreted. Records that we looked at also flagged ten patients who had a potential misdiagnosed case of diabetes. In four of these potential diabetes' cases that we looked at, the patients had abnormal blood results that had been filed by a clinician and not followed up. After the inspection, the provider told us they had followed up these four patients.

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) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.78	0.89	0.70	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). (01/04/2020 to 31/03/2021) (NHSBSA)	8.6%	10.0%	10.2%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2020 to 31/03/2021) (NHSBSA)	5.33	5.54	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	342.1‰	241.7‰	126.9‰	Variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	1.05	0.63	0.66	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	7.3‰	6.3‰	6.7‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y

Medicines management	Y/N/Partial
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	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.	N
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.	N
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	
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

Explanation of any answers and additional evidence:

Structured medication reviews were not being carried out. We saw evidence that some of these were done remotely at weekends, when the practice was closed and without a consultation with the patient.

The responsibility for the monitoring of high-risk medicines at the practice was given to the clinical pharmacists, in the main. We could not be assured that blood results were checked by clinicians at the time of signing repeat prescriptions. This made the lack of a structured medication review more relevant, as the need for blood testing would have been picked up during that process. Our clinical records' searches identified six patients who had not had timely and appropriate monitoring for high risk medicines. After the inspection, the provider told us they had contacted those patients to arrange the appropriate monitoring.

Medicines management	Y/N/Partial
During interviews, some GPs could not explain the process for high risk monitoring and prescribing. We were told by the provider that this was because not all GPs at the practice were given the responsibility for signing repeat prescriptions.	

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
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:	16
Number of events that required action:	16

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

Event	Specific action taken
A patient was treated for a urinary tract infection with a short course of antibiotics, but the problem did not resolve. When they called back to explain the symptoms were persisting, the practice advised the patient to wait for urine culture results. The patient's symptoms deteriorated and there was a delay in further treatment.	The provider reminded all staff that when patients call back with worsening or persisting symptoms a further clinical opinion is best sought to help guide appropriate action.
A patient had a repeat blood test undertaken for ongoing raised HbA1C levels (a blood test which indicates diabetes). The results were filed by a clinician as 'satisfactory – no action' even though they were abnormal.	Filing clinicians were reminded by the provider that they must review results in the context of previous results and notes, when filing.

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

Explanation of any answers and additional evidence:

We saw examples of actions taken on recent alerts for example, sodium valproate. Since April 2018, valproate has been the subject of a safety alert. Valproate is contraindicated in women of childbearing potential unless they meet the conditions of a Pregnancy Prevention Programme. However, we saw that two female patients of childbearing age were at risk of taking valproate without a pregnancy prevention programme in place. The provider told us they had assessed the risks of this, but they had not effectively documented the discussion with the patient or carer. There was no indication of mental capacity or best interest assessment in the patient records.

Effective Rating: Requires Improvement

At our February 2020 inspection, we saw that the performance results for cervical screening, chronic obstructive pulmonary disease (COPD) and mental health indicators were below average. The results for asthma reviews were also below average. At this September 2021 inspection, we saw that performance results in these areas had still not improved. We saw that the arrangements for initiating 'Do Not Attempt Cardiopulmonary Resuscitation' processes or advanced decisions were not being applied correctly. **We have again rated the practice as Requires Improvement for providing effective services.**

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N
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
Explanation of any answers and additional evidence: The monitoring of patients with long term conditions was below expected levels and staff told us they struggled to carry out effective reviews of these patients because the appointment times afforded to them had been halved.	

Older people

Population group rating: Requires improvement

Findings

We rated this population group as requires improvement because:

- We saw evidence of a lack of structure in the provider's annual medicines reviews. Sometimes these were done without any discussion or engagement with the patient.
- Patients over 75 years of age were eligible for health checks, including frailty assessments, but not all clinicians had offered these.

We also found that:

- 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 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.
- We saw evidence of a lack of structure in the provider's annual medicines reviews. Sometimes these were done without any discussion or engagement with the patient.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Patients over 75 years of age were eligible for health checks, including frailty assessments, but not all clinicians had offered these.
- 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

We rated this population group as requires improvement because:

- We saw evidence of a lack of structure in the provider's annual medicines reviews. Sometimes these were done without any discussion or engagement with the patient.
- Some staff told us they could not effectively carry out reviews of patients with long-term conditions, in the time they were allocated by the provider.

We also saw that:

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. Some staff told us that the appointment times for these reviews were not long enough for an effective review.
- Staff who were responsible for reviews of patients with long-term conditions had not always received specific training.
- The practice shared information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could not consistently demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. Records we looked at showed there were gaps in diagnosis.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were not offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were not always assessed for stroke risk and treated appropriately.
- Patients with COPD were not always offered rescue packs. Data for the practice's reviews for patients with COPD were below local and national averages.
- Data for the practice's reviews for patients with asthma were below local and national averages.

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	61.6%	78.4%	76.6%	Variation (negative)

RCP questions. (01/04/2019 to 31/03/2020) (QOF)				
PCA* rate (number of PCAs).	18.5% (93)	15.1%	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 the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	59.6%	91.8%	89.4%	Significant Variation (negative)
PCA rate (number of PCAs).	8.4% (21)	15.5%	12.7%	N/A

***PCA**:. Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	84.1%	85.3%	82.0%	No statistical variation
PCA* rate (number of PCAs).	4.9% (9)	5.6%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	59.8%	69.4%	66.9%	No statistical variation
PCA rate (number of PCAs).	15.5% (75)	16.8%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	69.2%	76.9%	72.4%	No statistical variation
PCA rate (number of PCAs).	7.1% (57)	8.0%	7.1%	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 (01/04/2019 to 31/03/2020) (QOF)	90.7%	92.9%	91.8%	No statistical variation
PCA rate (number of PCAs).	4.4% (7)	4.1%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	70.2%	78.2%	75.9%	No statistical variation
PCA rate (number of PCAs).	5.6% (27)	10.3%	10.4%	N/A

***PCA**:. Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Any additional evidence or comments
Some staff told us that appointment times for long term conditions had been halved recently.

Families, children and young people Population group rating: Good

Findings
The practice had met the minimum 90% for all five childhood immunisation uptake indicators. The practice had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of five childhood immunisation uptake indicators. 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), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	56	60	93.3%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	59	62	95.2%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	59	62	95.2%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	59	62	95.2%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	64	65	98.5%	Met 95% WHO based target

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 lead nurse had left the practice, and this had impacted upon the nursing team in terms of clinical leadership, supervision, clinical administration time, and undertaking additional training. Some nurses told us that they did not feel they could effectively carry out reviews for long term conditions in the allotted appointment times, which had been halved in duration.

Working age people (including those recently retired and students)

Population group rating: Good

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 limited access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74, due to the lack of face-to-face appointments offered during the pandemic.
Patients could order repeat medicines 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). (Snapshot date: 31/03/2021) (Public Health England)	76.4%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	75.5%	70.0%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	60.1%	61.5%	63.8%	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 (01/04/2019 to 31/03/2020) (QoF)	59.1%	94.9%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	68.4%	57.4%	54.2%	No statistical variation

Any additional evidence or comments

The practice provided some unvalidated data ('How Am I Driving?') which indicated that the practice's cervical screening rate for women aged 25 to 49 was 79.3%, and 79.6% for women aged 50 to 64 at the time of our inspection.

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. 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: Good

Findings
The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long-term medicines. 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. 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 (01/04/2019 to 31/03/2020) (QOF)	76.3%	88.4%	85.4%	No statistical variation
PCA* rate (number of PCAs).	15.6% (7)	25.2%	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)	66.7%	83.0%	81.4%	Tending towards variation (negative)
PCA rate (number of PCAs).	6.7% (6)	8.3%	8.0%	N/A

***PCA**:. Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

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	England average
Overall QOF score (out of maximum 559)	499.5	533.9
Overall QOF score (as a percentage of maximum)	89.4%	95.5%
Overall QOF PCA reporting (all domains)	6.2%	5.9%

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

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

The provider carried out an audit of subclinical hypothyroidism (a condition which is associated with risks of osteoporosis if left untreated). The audit required a further cycle of analysis but had demonstrated initial areas for quality improvement in clinical practice.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	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.	Partial
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.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y

There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: Some staff told us that their learning time was not protected. The induction programme we saw was limited in its scope. The aim of this process was to ensure all staff had the knowledge and skills necessary to perform their role safely and understand the central purpose of the practice. However, we saw no assurance system in place to demonstrate that new starters had read and understood the practice policies or were equipped to carry out their role once they had signed the induction form.	

Helping patients to live healthier lives

Staff were not 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.	N
Patients had access to appropriate health assessments and checks.	N
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: There was a lack of effective monitoring of some patients and they did not always undergo health assessments and checks within the indicated timeframe.	

Consent to care and treatment

The practice was unable to demonstrate that it 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.	Partial
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	N
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	N
Explanation of any answers and additional evidence: The practice had coded 49 patients as having a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision in place. We looked at five of these records, at random, during our inspection. In all five records we saw that there was no information or detail behind the decision making. There was an absence of recording that the patients had met the test for capacity to make the decision. It was	

unclear how the process for reviewing this annually was being carried out consistently. There was no recording of what a patient should do if they changed their mind about the DNACPR decision.

Caring Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

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

Source	Feedback
NHS website	There were four reviews left by patients within the previous 12 months. Three out of the four were positive about the professionalism of staff. One review was negative about access to appointments.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	81.9%	88.9%	89.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)	83.7%	88.4%	88.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	91.1%	95.3%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	68.5%	83.2%	83.0%	Tending towards variation (negative)

Any additional evidence or comments
The practice carried out its own patient survey and had put plans in place to address the areas that fell short of satisfaction, for example: • Increasing the incoming telephone lines by 50% capacity • Conducting a call quality review • Promoting the use of electronic consultation systems

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

Any additional evidence
The practice team had undertaken Lesbian, Gay, Bisexual, Transgender plus [plus represents other groups of gender and sexual minorities] (LGBT+) training and were awarded achievement in the LGBT+ champions scheme.

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

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 (01/01/2021 to 31/03/2021)	85.9%	92.8%	92.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	N

Information leaflets were available in other languages and in easy read format.	N
Information about support groups was available on the practice website.	N
Explanation of any answers and additional evidence: The practice had removed patient information leaflets due to Covid-19 arrangements. There was information on the practice website for people needing assistance with food during the pandemic.	

Carers	Narrative
Percentage and number of carers identified.	There are 165 patients identified as carers which makes up 2.5% of the practice patient list.
How the practice supported carers (including young carers).	The practice offered carers an annual flu vaccine and, prior to the Coronavirus pandemic, signposted patients to carers' groups.
How the practice supported recently bereaved patients.	Patients were offered a telephone call or a visit, where appropriate

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
Explanation of any answers and additional evidence:	

Responsive Rating: Requires Improvement

At our February 2020 inspection we rated the practice as Requires Improvement for providing responsive services because the way the practice organised and delivered services did not always meet patients' needs. The national GP patient survey, and complaints received by the Care Quality Commission indicate that patients still feel they cannot access care and treatment in a timely way. Feedback from staff highlighted difficulties in providing GP appointments to patients. **We have again rated the practice as Requires Improvement for providing responsive services.**

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.	Partial
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	N
Explanation of any answers and additional evidence: The provider was not aware of the requirement (through Accessible Information Standards) to identify, record, flag, share and meet the communication needs of people with a disability, impairment or sensory loss. They told us that since the Coronavirus pandemic they no longer issue patient information in a written format. However, we were told that they would send out letters for patients in larger font, if they had a visual impairment.	

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8.00am – 6.00pm
Tuesday	8.00am – 6.00pm
Wednesday	7.00am -6.00pm (7.00am – 8.00am Phlebotomy Clinic)
Thursday	8.00am – 6.00pm

Friday	7.00am – 6.00pm (7.00am – 8.00am GP appointments and Treatment Room Clinic)
Appointments available:	
Monday	8.15am – 5.30pm
Tuesday	8.15am – 5.30pm
Wednesday	8.15am – 5.30pm
Thursday	8.15am – 5.30pm
Friday	8.15am – 5.30pm

Older people

Population group rating: Requires Improvement

Findings

We rated this population group as requires improvement because the following issues could potentially impact on all patients, including this population group:

- Feedback from staff highlighted difficulties in providing GP appointments to patients
- The provider did not have an awareness of Accessible Information Standards.

We also found that:

- All patients had a named GP who supported them in whatever setting they lived.
- The practice offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice enabled older patients to access appropriate services.

People with long-term conditions

Population group rating: Requires improvement

Findings

We rated this population group as requires improvement because the following issues could potentially impact on all patients, including this population group:

- Feedback from staff highlighted difficulties in providing GP appointments to patients
- The provider did not have an awareness of Accessible Information Standards.

We also found that:

- Patients with multiple conditions did not always have their needs reviewed in one appointment.
- The practice provided limited care for patients with long-term conditions to access appropriate services.
- The practice liaised with the local district nursing team and community matrons to discuss and manage the needs of patients with 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: Requires Improvement

Findings

We rated this population group as requires improvement because the following issues could potentially impact on all patients, including this population group:

- Feedback from staff highlighted difficulties in providing GP appointments to patients
- The provider did not have an awareness of Accessible Information Standards.

We also found that:

- Additional nurse appointments were available school age children so that they did not need to miss school.
- 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.
- 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: Requires Improvement

Findings

We rated this population group as requires improvement because the following issues could potentially impact on all patients, including this population group:

- Feedback from staff highlighted difficulties in providing GP appointments to patients
- The provider did not have an awareness of Accessible Information Standards.

We also found that:

- 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.

People whose circumstances make them vulnerable

Population group rating: Requires improvement

Findings

We rated this population group as requires improvement because the following issues could potentially impact on all patients, including this population group:

- Feedback from staff highlighted difficulties in providing GP appointments to patients
- The provider did not have an awareness of Accessible Information Standards.

We also found that:

- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice 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: Requires improvement

Findings
We rated this population group as requires improvement because the following issues could potentially impact on all patients, including this population group: • Feedback from staff highlighted difficulties in providing GP appointments to patients • The provider did not have an awareness of Accessible Information Standards. We also found that: • Priority appointments were allocated when necessary to those experiencing poor mental health. • The practice was aware of support groups within the area and signposted their patients to these accordingly.

Access to the service

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

National GP Survey results

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

Explanation of any answers and additional evidence:

All patient information leaflets had been removed from the practice and not all staff were aware of Accessible Information Standards. However, the practice had appropriately coded patients who faced communication barriers:

Whose first language is not English – 48
Have a hearing difficulty - 588
Have a visual impairment - 928
Have a learning difficulty - 66
Have a carer - 267

We were told that interpreters were used, along with a text messaging facility and longer appointment slots to overcome communication barriers for some groups of patients.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	51.1%	N/A	67.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	53.8%	69.8%	70.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	41.7%	66.5%	67.0%	Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	70.8%	82.2%	81.7%	No statistical variation

Any additional evidence or comments
The practice's patient survey highlighted that patients would like to get back to face-to-face appointments. The provider told us they are restricted by national and regional protocols and do not wish to undermine public health guidance. Communication sent out from NHS England in May 2021 (Accees to General Practice Communications Toolkit, June 2021) outlined the need for practices to offer face-to-face appointments, while adhering to social distancing and IPC guidance.

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	12
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

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient complained regarding lack of access to appointments and felt that there was a delay in the service referring them for surgery.	The practice launched a patient feedback survey to ensure patients were asked about the quality of their communication from practice staff.
Four separate unrelated complaints were received in the same day about one of the GPs.	Additional communication skills training was arranged for the GP as well as a reminder regarding the expectations for conduct with patients. The GP no longer works at the practice.

Well-led Rating: Requires Improvement

At our February 2020 inspection we rated well-led services at the practice as Good. This was because we saw that the provider had significantly improved its arrangements for managing risks, issues and performance. There had been improvement in the overall governance that were previously inadequate. However, at this September 2021 inspection, we saw that the provider had not been able to sustain some of the previous improvements. We found new concerns regarding the governance of medicines' management, test results, and risk ratings of significant events. **We have rated the practice as Requires Improvement for providing well led services.**

Leadership capacity and capability

Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence: We saw evidence that the provider had prioritised the concerns raised at the last inspection as a platform for introducing change. Several matrices and systems had been developed and implemented to provide managers and leaders with oversight of operational issues.	

Vision and strategy

The practice had a clear vision, 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.	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.	Partial
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
Explanation of any answers and additional evidence: Some staff told us they were not involved in developing the strategy.	

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
Explanation of any answers and additional evidence: We saw evidence that the provider had taken action where a clinician's behavior was inconsistent with the practice's values.	

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

Source	Feedback
CQC Staff Questionnaires	**Some staff told us:** There is not enough time for training. There are not enough staff – patients struggle to secure GP appointments. Staff feel under a lot of pressure due to the demands of Covid but also from having a high volume of work. Staff work well as a team and try their best to help each other out. Sometimes feedback from suggestions and improvements is not received. Suggestions or concerns are not always acted upon. Appointment times have been halved in some instances. The management team are approachable and friendly.

	There are regular team meetings held so group discussions and support are available for each other.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y

Managing risks, issues and performance

The practice had processes for managing risks, issues and performance but they needed to be improved.

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

Explanation of any answers and additional evidence:
The provider had developed a clinical risk register matrix which incorporated likelihood, impact, severity and mitigating actions. However, not all of the risks on the register aligned with the risks that we found during our inspection, for example, the management of medicines and the management of long-term conditions.

We saw evidence that clinical incidents were a standing agenda item at regular meetings and were widely discussed in the practice. The provider told us they had identified themes and trends and taken action against them. However, the grading of these incidents did not always reflect themes and trends. For example: there were five incidents logged under the category ‘results interpretation’ since our previous inspection. In each case the likelihood afforded to these incidents was ‘extremely unlikely’, the impact was considered ‘low’ or ‘negligible’ and each of the events was graded as ‘minor’. This meant that root cause analysis was not properly carried out and it gave potential for similar incidents, which carried significant clinical risks to patients, to recur.

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: The introduction of a secure cloud-based communication and collaboration application had been introduced prior to our last inspection. All staff were able and expected to access this, regularly. The app was a place where; policies and protocols could be discussed; changes could be implemented and assistance with workplace matters could be sought. All topics were searchable through the use of a hashtag. Some staff told us they had welcomed the introduction of this system and it had positively enhanced their working experience and improved communication. Some staff felt that it was not an appropriate method of communication in some instances. We saw that the practice had a protocol in place to support the use of the app. However, there was no mechanism in place to assure the provider that staff had read and agreed to the terms and conditions of usage.	

Governance and oversight of remote services

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

Engagement with patients, the public, staff and external partners

The practice 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.	Y
The practice had an active Patient Participation Group.	Y
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

Feedback from Patient Participation Group.

Feedback
Members told us that: Complaints or compliments are seen as part of the learning curve so that best practice does not stop at an aspiration but also becomes a reality. Their views are listened to and improvements are made. Patient feedback is discussed in PPG meetings and is the basis for improvement at the practice.

Continuous improvement and innovation

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

	Y/N/Partial
There was a focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y

Examples of continuous learning and improvement
The provider had acted upon the areas for improvement previously identified by CQC. They had worked closely with the local clinical commissioning group to try to improve quality.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted

that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease.
- **PHE**: Public Health England.
- **QOF**: Quality and Outcomes Framework.
- **STAR-PU**: Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ***PCA**: Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see GMS QOF Framework). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
-
- ‰ = per thousand.