Care Quality Commission

Inspection Evidence Table

The Aldergate Medical Practice (1-554804406)

Inspection date: 15 July 2021

Date of data download: 08 July 2021

Overall rating: Good

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

Safe Rating: Good

At the previous inspection on 8 May 2019 we rated the practice as requires improvement for provision of safe services. This was because recruitment files did not contain all the required information; the training matrix was not up to date; documented risk assessments were not in place for emergency medicines not held in stock; there were gaps in fire drills, safety alerts, and serial number logs for paper prescription pads; gaps in system for repeat prescribing of a certain medicine and the significant event process lacked a route cause analysis and missed opportunities for further learning.

As a consequence of the improvements seen during the inspection in July 2021, the practice was rated as Good for providing a safe service.

Safety systems and processes

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

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

Safeguarding	Y/N/Partial
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial

Explanation of any answers and additional evidence:

Safeguarding policies and procedures were in place. However, these policies needed to be updated to reflect the current requirements for staff training. When we reviewed the training records, we saw that staff had received the appropriate level of training for their role.

The practice had a clinical safeguarding lead, with deputising arrangements in place. However, not all staff were aware of the deputising arrangements, although they knew where to access the policies to find the information. The safeguarding lead maintained registers for both children and adults, which were reviewed and updated every three months. The practice did not hold regular meetings with other health and social care professionals due to the demands of other services, but systems were in place to share information as required. The safeguarding lead reviewed and updated the child protection register every three months. Systems were in place to share information with other health and social care professionals as required.

We found there were systems to identify and follow up children, who were at risk, for example, children and young people who were not brought for appointments, did not attend secondary care appointments or who had a high number of accident and emergency (A&E) attendances.

The practice was unable to locate evidence of Disclosure and Barring Service (DBS) checks for three members of ancillary staff who had worked at the practice for a number years. The practice informed us that they had applied for new DBS checks for these members of staff.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes

Explanation of any answers and additional evidence:

During the inspection in May 2019, we found that recruitment files did not contain all the information required and were not well organised. We also found that there were gaps in staff's full vaccination histories in records we reviewed.

During the desk based review on 29 April 2021, we looked at three staff files. We saw that the practice manager had introduced a checklist to ensure that all of the required recruitment information was obtained, and the files were well organised. We found that with the exception of one file, which did not contain references, all the required information was available. We saw that full vaccination histories were on file for these members of staff.

During the inspection on 15 July 2021, we saw that appropriate recruitment checks were in place for two recently recruited members of staff.

The practice manager told us there was a system in place to ensure that the registration of clinical staff was checked and regularly monitored.

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: Various dates	Yes
There was a record of equipment calibration. Date of last calibration: 4 June 2021	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
A fire risk assessment had been completed. Date of completion: 2 October 2020	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: During the inspection in May 2019, we found there was no completed log of fire drills. In addition, we saw that the fire risk assessment was over due for review identified as for review September 2018. Not all actions highlighted in the last risk assessment had been signed off as completed and there was no clear audit trail of actions taken. We reviewed the training matrix and found that at a number of staff were overdue their fire safety fresher training. During the desk based review on 29 April 2021, the practice provided evidence that a fire drill had been completed in February 2020. The practice experienced a false fire alarm incident in August 2020 and had used this experience as a learning opportunity. The fire risk assessment had been updated in 2 October 2020 and all actions addressed. During the desk based review on 29 April 2021 we reviewed the training matrix. This indicated that one clinician was overdue their fire training. The training matrix identified when staff had completed their training, when it was becoming due and when overdue. The practice had recently changed the frequency of training to annually for all staff and were aware that a number of staff were now due for refresher training. During the inspection on 15 July 2021, we saw that fire and health and safety training was included in the induction and updated on an annual basis.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: Various dates	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Various dates	Yes
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.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: April 2021	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Partial

Explanation of any answers and additional evidence:

A legionella irks assessment had been completed in June 2021.

During the inspection on 15 July 2021, we saw that not all sharps boxes had been replaced after three months of use. We saw one box which was dated February 2021. This box was replaced immediately during the inspection.

Staff told us they had been provided with the required personal protective equipment. They said they had received additional training on the new guidance and were kept informed of any changes. Inhouse cleaners were employed, who had access to cleaning schedules and information was available for the products used in relation to Control of Substances Hazardous to Health (COSHH).

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes

Explanation of any answers and additional evidence:

We saw that staff received training on how to respond to medical emergencies and had access to equipment and emergency medication as appropriate. Reception staff explained the action they would take in response to a deteriorating or acutely unwell patient.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence: There were systems in place to share information regarding do not attempt cardiopulmonary resuscitation plans and/or anticipatory care planning for end of life care. Those patients with forms in place were identified on the electronic patient record.	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.83	0.79	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)	12.3%	11.1%	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)	7.38	6.05	5.37	Variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	151.6‰	153.4‰	126.9‰	No statistical variation
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)	0.66	0.50	0.66	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	2.8‰	3.8‰	6.7‰	Variation (positive)

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes

Explanation of any answers and additional evidence:

During the inspection in May 2019, we found a system was not in place to manage and monitor the use of prescription stationary. In addition, risk assessments were not in place to relation to emergency medicines not held at the practice.

During the desk based review on 29 April 2021, we saw that a prescription security protocol was in place, and log sheets had been introduced for monitoring the use of prescription stationary. We also reviewed the list of emergency medicines held at the practice. We saw that risk assessments had been completed for the suggested medicines not held. We reviewed this on the inspection on 15 July 2021 and saw that the risk assessments remained in place.

During the desk based review on 29 April 2021, we carried out a remote review of patient records. This review highlighted potential issues with monitoring the health of patients prescribed high risk medicines and management of safety alerts, which required further investigation. The initial results were shared with the practice. The practice reviewed the initial results and carried out a number of audits, which they shared with the Care Quality Commission (CQC). The audits highlighted a number of issues, including incomplete use of electronic codes on patient records, lack of or out of date monitoring of

Medicines management	Y/N/Partial

blood results and no clear rationale or discussion in the patient records to support the prescribing of medicines.

During the inspection on 15 July 2021, we undertook an onsite review of patient records. We saw that the practice had taken action to address the issues highlighted in April 2021 and improvements had been made. We saw that patients prescribed high risk medicines had their health monitored prior to repeat prescriptions being issued. Discussion took place around the local challenges of obtaining blood results via the hospital pathology system, and it was suggested that if the results were viewed online, it was recorded in the patient record. We saw that the practice had taken action to review patients prescribed combinations of medicines to ensure they were on the correct dosage and/or combination of medicines.

We reviewed three records for patients prescribed a medicine used in the event of seizures and who therefore required family planning advice. Following the desk based review in April 2021, the practice had reviewed all patients prescribed this medicine. Patients who required this specific medicine were appropriately referred to a secondary care consultant. However, some of these patients required an up to date review as the practice had identified that the appropriate form completed by the specialist had expired for a number of patients. The practice had requested the completion of new forms. For those patients reviewed, we saw evidence of discussion of the risks associated with the medicine and pregnancy and the use of contraception. Written information had also been provided to any patients who took this medicine.

The practice was aware that their prescribing of certain types of antibiotics was above average. Staff working in advanced roles told us that their prescribing was audited and the practice was working towards reducing the level of antibiotic prescribing.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong/did not have a system to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Partial
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	6
Number of events that required action:	6

Explanation of any answers and additional evidence:

During the inspection in May 2019, we found that ssignificant events and incidents were reported documented and actioned with lessons learnt shared and disseminated. However, the system lacked a route cause analysis and therefore missed opportunities for further learning.

During the desk based review on 29 April 2021, we saw that the practice had introduced route cause analysis for significant events. We reviewed the root cause analyses for five significant events, which explored and recorded actions to be taken to reduce or mitigate risk of occurrence.

Discussion with practice staff indicated that the vaccine fridge had failed in 2020. Staff described how they had followed the cold chain procedure, quarantined the vaccines, contacted the relevant people and reported the vaccines as off licence. As this had not been recorded as a significant event, the opportunity to discuss how staff had followed procedures and maintained patient safety had been missed.

The practice had reported six significant events between April 2020 and March 2021. We looked at two in detail. We saw that full details of the investigation were not always recorded on the significant event form, although a root cause analysis had been completed.

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

Event	Specific action taken
A cervical cytology sample had been incorrectly labelled and sent to the laboratory for processing.	The error was identified by the laboratory and reported to the practice. The patient was contacted, an apology given, and a further appointment scheduled for three months' time. The member of staff reflected on how the incident occurred and identified areas for learning. Consequently, labels are printed as the patient arrives for their appointment, and a second member of staff checks the specimens and the labels.
A patient's medicines were not amended in line with information received in the hospital discharge letter.	The required changes to the medicines had not been completed promptly due the practice pharmacist not being available. The member of staff who had initially processed the correspondence had not identified that the information was time critical. In additional, alternative arrangements had not been made for cover when the pharmacist was absent. The practice had introduced a system where medicine changes were passed to a GP to process in the absence of the pharmacist.

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

Explanation of any answers and additional evidence:

During the inspection in May 2019, we found that the practice did not have a system approach to ensure that safety alerts had been actioned. Immediately following the inspection, the practice informed us that they had developed a spreadsheet available for all staff on patient safety alerts arranged in monthly folders with links to the outcomes and any actions taken and that this would be discussed at weekly meetings as appropriate.

During the desk based review on 29 April 2021, we saw that a spreadsheet had been introduced. However, when we reviewed the spreadsheet, we noted that not all of the alerts and updates that were published were recorded on the spreadsheet. Therefore, the required searches and actions had not been undertaken.

During the inspection on 15 July 2021, the practice manager told us that they now had systems in place to ensure they received all of the alerts and updates that were published.

We saw examples of actions taken on recent alerts for example, sodium valproate (Medicines used to treat epilepsy). Where relevant, the patient had been informed of the risks of taking the medicine.

Effective Rating: Good

Effective needs assessment, care and treatment

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

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

Explanation of any answers and additional evidence:

We saw that clinicians made good use of the templates and guidance that was available in the electronic patient record. We saw that these had been completed appropriately.

Clinical staff had a designated mentor and clinical supervision and support was provided.

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. Patients were referred to the frailty clinic and received a full assessment of their physical, mental and social needs.
- The practice worked closely with the care co-ordinator to support elderly patients. The care co-ordinator liaised with community staff and the social prescriber to support patients.
- 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 medicines reviews for older patients, including those living in a care setting.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered home blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	65.7%	71.1%	76.6%	Tending towards variation (negative)
PCA* rate (number of PCAs).	4.7% (46)	10.8%	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)	90.4%	84.7%	89.4%	No statistical variation
PCA rate (number of PCAs).	2.1% (5)	12.2%	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)	69.6%	78.7%	82.0%	Variation (negative)
PCA* rate (number of PCAs).	2.0% (7)	4.6%	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)	53.1%	61.3%	66.9%	Tending towards variation (negative)
PCA rate (number of PCAs).	7.2% (46)	12.3%	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)	61.4%	68.2%	72.4%	Tending towards variation (negative)
PCA rate (number of PCAs).	3.4% (54)	6.0%	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)	89.8%	90.3%	91.8%	No statistical variation
PCA rate (number of PCAs).	2.5% (8)	3.5%	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)	55.0%	73.8%	75.9%	Variation (negative)
PCA rate (number of PCAs).	5.8% (37)	10.0%	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

The practice had plans in place for patients overdue their annual review of their long term conditions. This included identifying and inviting patients to attend. The practice planned to coincide the patients month of birth with their annual health review date. Staff spoken with were aware the practice performance was below average in some areas and were prioritising these patients for reviews.

Families, children and young people Population group rating: Good

Findings

- The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for two of five childhood immunisation uptake indicators. However, this target would have been achieved had one additional child received their immunisation in each indicator.
- 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 safeguarding lead reviewed and updated the child protection register every three months. Systems were in place to share information with other health and social care professionals as required.
- 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 and the practice offered an emergency contraception service.
- 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)	123	129	95.3%	Met 95% WHO based target
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)	108	113	95.6%	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)	107	113	94.7%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	107	113	94.7%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	141	147	95.9%	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 practice had a system in place to invite children for their immunisations. The practice operated two child immunisation clinics each week, one in the morning and one in the afternoon to accommodate the needs of patients. The practice monitored those children who did not attend for immunisations and contacted the parent / guardian to rebook an appointment. Children who consistently failed to attend for immunisations were referred to the practice safeguarding lead, who liaised with the health visitor when it was appropriate to do so.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice was involved in the catch up programme for the meningitis vaccine, for example for those who had not been vaccinated at school
- 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.
- Patients order repeat medicines without the need to attend the surgery.
- The practice offered a travel health and immunisation service.

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: 31/12/2020) (Public Health England)	71.9%	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)	74.5%	74.2%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	65.4%	63.4%	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)	90.7%	92.6%	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)	61.0%	49.3%	54.2%	No statistical variation

Any additional evidence or comments

The practice was below the 80% target for cervical cancer screening. The practice had a system in place to invite patients for cervical cancer screening. Staff told us that those patients whose screening had been postponed due to the Covid-19 pandemic had been invited to attend. Staff opportunistically reminded patients during consultations if they were overdue their screening and encouraged them to book an appointment.

Breast and bowel screening uptake was in line with or above the national averages.

People whose circumstances make them vulnerable

Population group rating: Good

Findings
• Same day appointments and flexible 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 reviewed young patients at local residential homes. • The practice was a Veteran accredited practice. • The practice provided care for patients in a specialist care home for people with Prada Willi Syndrome. Staff had received training on the care and treatment of this condition.

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. • Same day and flexible appointments were offered when required. • There was a system for following up patients who failed to attend for administration of long-term medicines. • 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)	85.7%	81.5%	85.4%	No statistical variation
PCA* rate (number of PCAs).	12.5% (12)	12.0%	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)	71.3%	80.1%	81.4%	No statistical variation
PCA rate (number of PCAs).	5.0% (6)	4.4%	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 programme of quality improvement activity and reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	507.3	533.9
Overall QOF score (as a percentage of maximum)	90.8%	95.5%
Overall QOF PCA reporting (all domains)	3.4%	5.9%

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

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

The practice had undertaken eight audits following the initial Care Quality Commission remote review of patient records in April 2021, which highlighted potential issues with the monitoring of patients on high risk medicines and the management of safety alerts. The practice audits examined the records of those patients who had been identified as requiring monitoring. These audits recorded the discussions

that had taken place, detailed a plan of action, next steps, and a date for when the audit would be repeated.

The practice had completed the first stage of a two stage audit looking at care planning for patients with dementia. The first stage identified those patients with a recognised code for dementia but without a code for the completion of a dementia careplan in the previous 12 months. The audit identified that 79 out of 143 patients coded with dementia did not have recognised code for a care plan.
A manual review of the patient records identified that:

- 36 of these patients did have a care plan in place but this had not been coded in the electronic record,
- 32 patients did not have dementia but had been identified in the search through other codes,
- 10 patients had a valid dementia code but were not under active review by the memory team and required a review to assess their needs
- One patient could have been miscoded.

An appropriate code was added for patients where a careplan was in place, so these patients would be identified using the search parameters. Consequently 110 patients were identified with the correct dementia code and of these, 100 patients had a care plan within the last 12 months. As a result, ten patients required a clinical review to either refer them back to the memory clinic if indicated, or code the reason why they were not under this service. The audit also highlighted an issue around the use of electronic codes on patient notes. The practice told us that codes would be defined and applied to ensure the correct patients were identified within the search parameters. The next stage of this audit was planned for September 2021.

Any additional evidence or comments

The practice had participated in the National Cancer Diagnosis Audit (NCDA). This is a national audit where practice review all cancer diagnoses during a set period of time and upload data on to a national database.

The nursing team had undertaken a hand washing audit, and stage one of a wound care audit.

Effective staffing

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

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

Explanation of any answers and additional evidence:

The practice worked with existing staff and encouraged and supported them to develop in their roles. Plans were in place for the reception manager to work more closely with practice manager to become familiar with the role as part of the practice's succession planning. Another member of staff had moved from a secretarial position to the role of personal assistant to the practice manager. In addition, members of the nursing team would be trained to carry out the fitting and removal of long acting reversible contraception.

The practice had developed competency frameworks for staff roles and written agreements were in place between the practice and the staff member. Arrangements were in place for clinical supervision of staff working in advanced roles, which included reviewing their consultations and antibiotic prescribing. Annual appraisals were completed by the designated GP and included input from the other GPs working within the practice.

Due to the challenges around recruitment, the practice had been innovative with new staff recruitment. Within the last 12 months they had recruited a pharmacist, two physician associates and a paramedic practitioner to work in advanced roles. These staff had a designated mentor, who they worked closely with for guidance and support. The competency framework was used to support the development and monitor progress of these staff.

All staff received an annual appraisal and were supported with their continual development. Staff were provided with protected learning time and used this to complete their required training. We reviewed the training matrix and saw that staff training was up to date. The practice manager recognised that the current system for recording training was not completely effective as it did not capture all training completed by staff and data had to be inputted manually.

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
Explanation of any answers and additional evidence: Staff attended end of life meetings with other health and social care professionals to discuss the care and treatment of patients. Systems were in place to share information with other health and social care professionals as required.	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence: The practice offered health checks and provided staff with the opportunity to discuss smoking cessation, alcohol reduction advice and weight loss. Patients were signposted to support organisations as appropriate. The practice provided printed information and electronic links to relevant guidance and literature for patients.	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence: We saw that clinicians completed health and social care plans called ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) which identified patients' wishes and the care they required. This incorporated an assessment of mental capacity and details of the patient's resuscitation status (i.e. if cardiopulmonary resuscitation should be given or not).	

Well-led Rating: Good

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes

Explanation of any answers and additional evidence:

The GP partnership had changed since the inspection in May 2019 and the registration with the Care Quality Commission (CQC) had been amended to reflect this. However, the registration of the previous Registered Manager had not been cancelled, nor had the proposed Registered Manager submitted an application to CQC to become registered.

We found that the leaders demonstrated that they understood the challenges to quality and sustainability. The partners had recognised the need for succession planning and had been innovative with new staff recruitment. Within the last 12 months they had recruited a pharmacist, two physician associates and paramedic practitioner to work in advanced roles. They also encouraged the development of existing staff and supported them through training to work in different roles within the practice. The practice was aware the two members of the nursing team planned to retire within the next few years and were actively recruiting to replace these roles. The practice had plans to appoint an apprentice with training towards Level 3 in Business Administration, with the specific role to manage data returns through the AccuRx system.

Staff spoke highly about the management team and commented that leaders were visible and approachable. Staff felt supported and valued in their work.

Vision and strategy

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

Explanation of any answers and additional evidence:

Staff we spoke with were aware of the practice vision and mission statement. The practice manager told us that staff had been asked for suggestions to review and update the practice strategy during their last protected learning time. The vision and mission statement was being updated and would be discussed at the next quality meeting, to confim that staff agreed with the statements. Staff told us they had been asked for their ideas regarding 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.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes

Explanation of any answers and additional evidence:

Staff told us that during the Covid-19 pandemic the management team had demonstrated a strong emphasis on the safety and well-being of staff. Changes had been made to the rotas, resulting in staff initially working in defined groups to reduce the number of contacts they had with different people. However, this was reviewed following feedback from staff as they felt that it affected their wellbeing. The reduce risk changes were made to the working practices within the building. For example, each member of staff was allocated their own desk rather than hot-desking, and they were responsible for keeping this area clean; spacing of desks and less staff working in an area, and a safe space had been created for when staff needed to take time out.

Staff told us they were able to raise any issues or make suggestions, either during meetings or as issues arose, and they would be listened to and supported as required. Staff knew they had access to a Freedom to Speak up Guardian.

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

Source	Feedback
Staff interviews	Staff told us that they enjoyed working at the practice, and the practice team felt like family. They felt empowered to make suggestions or raise any

	concerns. They said they were able to raise queries or concerns with any member of the management team, and they would be listened to and their comments taken on board. They told us support for their wellbeing was available and confidentiality would always be maintained.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence: Staff told us that clear governance arrangements were in place. Staff were clear about their roles and responsibilities and those of others, including the lead roles of clinicians.	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: The practice manager described the processes in place to manage the performance of the practice as well as staff. Practice performance was discussed at clinical and practice meetings. The management team had oversight of any identified risks and action had been taken to mitigate these. Staff were aware of the major incident plan and copies were kept off site by the management team.	

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

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

Explanation of any answers and additional evidence:

- To meet the demands of the Covid-19 pandemic, a GP appointment triage system had been introduced. Consultations were carried out remotely. At a GP's discretion, face to face appointments were offered. Patients could access appointments by telephoning the practice. Information to inform patients of the change in accessing appointments was included on the practice's website and the telephone answerphone system.
- The practice had constantly reviewed the appointment system to reflect the changes in guidance, as well as the needs of the patients and staff. To maintain staff wellbeing, GPs were allocated one patient facing session a day. For example, if they dealt with patients during a morning session, they dealt with other tasks such as incoming correspondence, test results or prescriptions during the afternoon.
- The ratio of appointments for GPs was five face to face appointments and ten telephone/video consultations per session. Face to face appointment times were split between the GPs on duty to minimise numbers in the waiting room, maintain social distancing and allow for cleaning between patients.
- There was a duty GP available each session, who provided cover and dealt with any queries or urgent cases unable to be seen by the other clinicians. They provided support and mentorship for the GP registrars and the physician associates, and contacted patients booked by NHS 111.
- The practice operated a duty screen for on the day appointments (either face to face or telephone consultation).
- The practice had started to introduce some pre-bookable telephone consultations. These were either pre-bookable three days in advance or the day before.
- Appointments, both telephone and face to face, were available with the advanced nurse practitioners and the practice nurses.
- The practice had reviewed patient activity during the first four months of the Covid-19 pandemic April 2020 to July 2020 against April 2021 to July 2021. The results demonstrated a 150% increase in calls answered (from 24,500 to 61612); 50% increase in clinical triage by phone or video link (from 9,911 to 14877); 180% increase in face to face appointments following triage

(from 591 to 1651); 85% increase in routine face to face appointments (from 2,570 to 4,761); 23% increase in issuing of medical certificates (from 290 to 358) and a 22% reduction in medicine requested processed (from 13,136 to 10,304).

- To support the communication needs of patients, carers and parents with a disability, impairment or sensory loss, there was an accessibility link on the practice's website.

The Care Quality Commission had received four comments from patients between October 2020 and Janaury 2021 regarding the challenges accessing appointments. One person had raised their concerns directly with the practice and commented positively about the response they had received.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence: The practice used the Quality and Outcomes Framework (QOF) to improve performance. We saw that QOF data was discussed at clinical staff meetings.	

Governance and oversight of remote services

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

Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Explanation of any answers and additional evidence: We saw that policies and systems were in place to manage the governance of remote services.	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: The practice had an active Patient Participation Group (PPG) and had maintained contact with the chairperson via email during the Covid-19 pandemic. The practice meet with the PPG via video conferencing on 28 June 2021 and another meeting was arranged for September 2021.	

Feedback from Patient Participation Group.

Feedback
We contacted the chairperson of the Patient Participation Group (PPG) and they shared the minutes of the last engagement meeting with us. They told us that the practice was very supportive of and co-operative with the PPG and answered any questions they raised during the meeting. The PPG felt that the practice could make better use of social media to inform patients regarding the changes that had taken place and continued to take place regarding the availability and type of appointments. The main concern raised by patients was around appointments, especially face to face and not all patients were aware this was a national issue and consequently were less understanding of the situation. The PPG felt that the practice had been innovative with new staff recruitment, providing patients with a variety of healthcare professionals to provide a service.

Any additional evidence
We looked at the reviews which had been posted by patients on the NHS website over the last 12 months. Half of these reviews were positive, and commented on the doctors being kind and caring, the efficient service provided at the flu clinic and making patients feel safe whilst on site during the Covid-19 pandemic. The remaining reviews were negative and commented on the challenges around getting through on the telephone and getting an appointment. The practice manager had answered the reviews individually and for those with negative comments, had encouraged the patient to make contact via the practice website, so their concerns could be investigated. We looked at the 2021 GP survey results, published 8 July 2021 and saw there had been an increase in patient satisfaction in relation to getting through to the practice by phone. Although the figures remained below the national average, the result had increased from 33% to 48% of patients who found it easy to get through to this GP practice by phone. However, there had been a decrease in patient

satisfaction with the type of appointment they were offered. This could have been a reflection of the increase in telephone and video appointments that have been offered during the last 12 months.

Healthwatch Staffordshire told us they had received general concerns about the practice which related to difficulty obtaining appointments and difficulty obtaining and sorting out prescriptions.

We spoke with representatives from four local care homes. They told us they generally had a good relationship with the GP practice, although some were frustrated at having to liaise with the care home outreach care co-ordinators first for some queries and requests. There were mixed views regarding GP visits, although the GPs did carry out video and telephone consultations.

Continuous improvement and innovation

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

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

Explanation of any answers and additional evidence:
The practice was committed to supporting staff to develop their skills and knowledge, to enable them to move to different roles within the practice.
The practice employed staff in advanced roles and provided clinical supervision and mentorship to support staff in these roles.

Examples of continuous learning and improvement
The practice had participated in the National Cancer Diagnosis Audit (NCDA). This is a national audit where practice review all cancer diagnoses during a set period of time and upload data on to a national database. The practice was investing in new IT software package (Ardens), which included evidence based and best practice resources and templates linked to clinical pathways. This system ran alongside the current electronic patient record system.

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.