

Inspection Evidence Table

Christchurch Family Medical Centre (1-541983599)

Inspection Date: 20 June 2023

Date of data download: 31/05/2023

Overall rating: Requires improvement

At this inspection in June 2023, we rated the practice as Requires improvement overall because:

- Systems and processes to support safe prescribing and monitoring of patients was not always effective to protect patients from harm.
- Patients did not always receive effective care and treatment that met their needs. In particular, identifying and monitoring patients with long-term conditions in line with national guidance.
- Governance processes were in place, but oversight of systems to monitor the quality of care in relation to the management of patients were not always effective. In particular, patients who were prescribed medicines that require monitoring, patients with long-term conditions and patients affected by safety alerts.
- Leaders did not always monitor staff performance and competency to drive improvement.

Safe

Rating: Requires improvement

We rated the practice as requires improvement for providing safe services because:

- Systems and processes to support safe prescribing and monitoring of patients were not always effective to protect patients from harm.
- Oversight of safeguarding training and alerts required further review and implementation to keep patients safe.

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse, however these were not always effective.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Y

The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<ul style="list-style-type: none"> The practice had appropriate safeguarding policies and processes in place. There were arrangements and key contacts to make a safeguarding referral. There was a system in place to identify patients with a safeguarding concern, however this was not always effective. We saw evidence of a patient record that had a safeguarding alert on the patient notes, however no other members of the patient household had also had this alert added. After the inspection, the practice reviewed these patient records to add appropriate alerts and developed a new policy that provided further guidance on this for all staff members. The safeguarding lead planned to work with key members of staff to improve the oversight of safeguarding concerns. This new policy required implementation and embedding to ensure it was effective. The practice had plans for the care co-ordination team to oversee and review safeguarding lists, however policies and processes were in draft form and it was unclear how leaders were going to ensure adequate oversight of safeguarding. The safeguarding lead attended local multi-disciplinary team (MDT) meetings, information from this was updated on patient notes and shared with the patients named GP. Not all staff had received appropriate safeguarding training. We reviewed staff training and found staff were allocated the appropriate level of safeguarding training for their role. Most staff allocated level 1 and level 2 safeguarding training had completed this. GP's and registered clinicians were required to complete level 3 safeguarding training, however we found 70% had completed adult safeguarding training and 71% had completed children safeguarding training. Processes to monitor all staff safeguarding training were not always effective. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
We reviewed 4 staff recruitment files and found the service held documentation in line with guidance and their recruitment policy.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: February 2023	Y
There was a fire procedure.	Y

Date of fire risk assessment: October 2022	Y
Actions from fire risk assessment were identified and completed.	Y
<ul style="list-style-type: none"> • Appropriate risk assessments were carried out which included premises, health and safety, hazardous substances. Actions were identified and completed. • During the on-site visit, we identified the practice had completed weekly fire alarm testing until March 2023, where this had stopped being recorded. We found this was subsequently being recorded on a monthly basis. Staff told us the weekly alarms were still being carried out and it was identified as an individual recording error. Following the inspection, the provider had reviewed the process and ensured this was being followed correctly. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: July 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
The service had carried out infection, prevention and control audits. Actions had been logged and completed at the time of inspection.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
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
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
A review of patient records in relation to the clinical searches carried out by a CQC GP specialist advisor identified that care records were managed in a way to protect patients.	

Appropriate and safe use of medicines**The practice had systems for the appropriate and safe use of medicines, including medicines optimisation, however these were not always effective.**

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	0.74	0.72	0.86	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). (01/01/2022 to 31/12/2022) (NHSBSA)	9.6%	8.5%	8.1%	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 (01/07/2022 to 31/12/2022) (NHSBSA)	4.16	4.54	5.24	Variation (positive)

Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) <small>(NHSBSA)</small>	78.3‰	89.9‰	130.3‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) <small>(NHSBSA)</small>	0.41	0.48	0.56	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) <small>(NHSBSA)</small>	4.4‰	5.1‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines. 1	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. 2	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Partial
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement 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.	NA
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.	Y
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 UKHSA guidance to ensure they remained safe and effective.	Y

During the site visit, we reviewed patient group directions (PGDs) and found that documentation was not completed in line with guidance. PGDs are a legal document that allows some registered health professionals to supply or administer specific medicines to a pre-defined group of patients without them having to see a prescriber. Post inspection, we were sent evidence this had been reviewed by the lead nurse and an action plan was in place to resolve the concerns.

On the day of inspection, we found that leaders did not have effective oversight of non-medical prescribers (NMP) competence for prescribing. Leaders did request non-medical prescribers (NMP) complete an annual prescriber self-declaration as part of their appraisal process and NMP's were required to complete reviews in line with their professional registration, however leaders did not review a selection of consultations to ensure safe practice. We raised this with leaders who told us it was difficult to pull data of this kind from their system and that with the pharmacy team reviewing patient notes routinely, they felt anomalies would be found. Post inspection, we were provided with examples of a NMP completing self-reflection on consultations with their line manager, however there was no evidence of line managers reviewing a sample prescribing from the NMP's in line with their competencies. Post inspection, the policy was updated to state all NMP's should request an prescribing report annually in line with their appraisal. At the time of inspection, leaders could not provide evidence they were assured that NMP's were all prescribing within their competencies or in line with guidance. The updated policies would need time to implement and embed to ensure they were effective.

The service did not have effective oversight of controlled drugs prescribing. The service told us they had completed 4 controlled drug audits in the past 12 months which focussed on specific groups of patients. Out of 4 of these audits 3 had been triggered by the Bristol, North Somerset, South Gloucestershire (BNSSG) medicines optimisation team. The service did not have a schedule to routinely review controlled drug prescribing by clinicians. We raised this with leaders and we were told that the integrated care board's prescribing quality team reviewed this and would alert them to any unusual controlled drugs prescribing. We were not assured the practice leaders were monitoring controlled drug prescribing effectively.

During the on-site inspection, we reviewed the services emergency bag and medicines. We found a 10mg Diazepam rectal solution to be out of date. Diazepam is a medicine that is used to treat seizures in an emergency situation. The staff member responsible for this was aware of this and had felt it was safer to keep the medicine in the due to delayed replacement availability, however this had not been risk assessed. Post inspection, we were provided with evidence that this medicine had been risk assessed and correspondence with management of this issue was shared with relevant members of staff.

Clinical searches by a Care Quality Commission (CQC) GP specialist advisor were carried out during this inspection and found the following:

- Patients prescribed Disease Modifying Antirheumatic Drugs (DMARDs, which are medicines used to treat autoimmune conditions) were being monitored safely. However, we identified that clinicians had not always added the day patients should be taking this medicine in line with guidance before processing the prescription.
- For patients who were prescribed medicines that require monitoring, we found out of 3037 patients prescribed an Angiotensin-converting enzyme (ACE) inhibitor or Angiotensin II receptor blockers (medicines used to treat high blood pressure) 91 had not received the correct monitoring. The practice had a process to identify patients who were overdue monitoring, however prescriptions continued to be issued.

We raised these findings with leaders and appropriate action was taken to review and mitigate the risks to these patients including: all patients being recalled for blood tests, of which 31 were booked for the following 14 days, remote medicine reviews and trialling a new medicine monitoring process which is due to be reviewed after 3 months for it's efficacy.

- The service had a process for completing medication reviews, however, they recognised that they had a high number of outstanding medicine reviews. The practice recognised that this process required a review and therefore planned to undertake a quality improvement audit with the vision to improve their processes. They were working with the areas medicines optimisation team to identify patients who may be at increased risk from harm.

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:	21
Number of events that required action:	21
<ul style="list-style-type: none"> • Staff told us they were supported to record incidents within the practice. Where the incident was easily rectified or managed on the same day, these were recorded as learning events. All learning events were reviewed and areas of improvement documented. We saw examples of actions taken such as reminders, communication with staff and process changes. 	

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

Event	Specific action taken
Whilst reviewing a patient, the GP noticed a missed diagnosis of diabetes in a patient.	<ul style="list-style-type: none"> • Patient was informed of the error. • Learning event raised. • Information was taken to a clinical meeting where a new protocol was developed by the pharmacy team. • Teaching sessions were arranged with the GP team with a focus of potential diabetic patient follow ups.

<p>A patient attended the practice to drop off a sample. They noticed they could see the names of other patients who had dropped off their samples within the box. They raised with the patient assistants.</p>	<ul style="list-style-type: none"> • The patient assistant escalated to a manager. • The position of the sample container was moved to a new location on the same day. • New containers were ordered and delivered to ensure patient identifiable information was kept confidential. • Signs were placed in the practice to inform patients of the change in process. • This was raised in the following nursing and patient assistant meetings. • The patient received a response regarding the changes and improvements made to reduce the risk of reoccurrence. The practice was open and honest which demonstrated compliance to the duty of candour.
---	---

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • During clinical searches carried out by a CQC specialist advisor, we reviewed how the practice responded to safety alerts. Medicines and Healthcare products Regulatory Agency (MHRA) issued an alert in 2014 telling health care providers that clopidogrel (a medicine to prevent blood clots) and omeprazole or esomeprazole (a medicine to treat indigestion) should not be prescribed together. We found 66 patients who were prescribed this combination of medicines. • The service did have a process for actioning alerts, but recognised this had not been effective for these patients. After the inspection, the practice created an action plan to identify, review and inform all of these patients with a completion date of 31 July 2023. Although the practice responded to our findings, we were not assured that the process was effective to keep patients affected by this safety alert safe. 	

Effective

Rating: Requires improvement

We rated the practice as requires improvement for providing effective services because:

- Patients did not always receive effective care and treatment that met their needs. In particular, identifying and monitoring patients with long-term conditions in line with national guidance.

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was 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. ¹	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. ³	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y

Effective care for the practice population

Findings

- Those identified received a full assessment of their physical, mental and social needs.
 - Health checks, including frailty assessments, were offered to patients over 75 years of age.
 - Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
 - The practice had systems to inform eligible patients to have the meningitis vaccine.
 - Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
 - All patients with a learning disability were offered an annual health check.
 - End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
 - The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
 - The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
 - Patients with poor mental health, including dementia, were referred to appropriate services.
-
- During CQC clinical searches, we looked at effective care and treatment of asthma patients. We found out of 1635 patients diagnosed with asthma, 31 patients had been issued more than 12 short-acting beta agonist (SABA) inhalers within the last 12 months. We reviewed 5 patients notes and found none had their overuse of inhalers discussed at their asthma review. Out of the 5, 3 were on variable repeat prescriptions. We raised this with leaders who told us that all these patients had a note attached to the prescription to highlight the overuse. After the inspection, the practice had requested all 31 patients complete a questionnaire about their asthma and would be offered a review by the asthma team. All these patients had their prescriptions changed from repeat to acute prescriptions in the interim and the practice told us they had been working with the area's medicine optimisation team to reduce the overuse of inhalers, but recognised further work was required. Leaders then further reviewed patients and found 14 patients had received an asthma and medicines review, 6 had received an asthma review but no medicines review, 10 had not attended their appointment and 1 had not received an invite for an asthma or medicine review for the overuse of SABA inhalers. Although we saw some action had been taken for most of these patients, further work was required to ensure safe prescribing of SABA inhalers.
-
- The clinical searches also identified patients who had a potential missed diagnosis of diabetes. Out of 56 patients identified in this search, we reviewed 5 of these patients records and found 2 did not meet the threshold for diabetes. From the remaining 3 patients, we found they were not informed of their diagnosis and had not yet started treatment. In response to our findings, the service reviewed all 56 patients and as a result, added 15 patients to the diabetic register. The remained 41 did not meet the diagnosis of diabetes but the service took action to monitor these patients. The service had developed a new process in March 2023 to support the diagnosis of diabetic patient, however it was not always effective. The practice had plans to increase the frequency of the potential missed diagnosis audits in line with their chronic disease recall schedule.

Management of people with long term conditions

Findings

Clinical searches by a Care Quality Commission (CQC) GP Specialist Advisor for this inspection showed patients received appropriate monitoring of their health and received a clinical review for long term conditions in most cases. The reviews from our searches included patients diagnosed with:

- Asthma who had had two or more courses of rescue steroids in the last year.
- Chronic kidney disease stage 4 or 5, which is a reduction in kidney function, structural damage or both.
- Hypothyroidism, a condition where the thyroid gland does not produce enough hormones.
- Diabetic retinopathy whose latest HbA1C result was more than 74mmol/l. Diabetic retinopathy is a complication affecting vision that can arise in people who have diabetes. HbA1c is a blood test that can give a picture of someone's blood glucose levels over the previous two to three months and therefore an indication of the management of their diabetes.
- We identified 933 patients with hypothyroidism, of which 29 patients had not had the correct monitoring. We reviewed 5 of these patients and in all 5 the practice had contacted these patients to advised they were overdue monitoring, but no further action had been taken. In all 5 patients, they were overdue a medication review also. We discussed this with leaders and after the inspection, we saw evidence that 18 of these patients had a blood test booked within 14 days of the inspection. The remaining 11 patients had been reviewed by the pharmacy team to assess the risk and their medication had been moved from a repeat request to acute one until the appropriate monitoring had been completed. The practice were trialling a new process that was due to be audited after 3 months to ensure it was effective.

Other examples of care provided included:

- Patients with long-term conditions were offered an effective 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 could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	295	302	97.7%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	303	314	96.5%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	303	314	96.5%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	299	314	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	292	311	93.9%	Met 90% minimum

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

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	66.5%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	73.9%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (31/12/2022 to 31/12/2022) (UKHSA)	77.6%	N/A	80.0%	Below 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	62.8%	56.7%	54.9%	No statistical variation

Any additional evidence or comments

During the site visit, we saw unverified data that the practice was at 80% for the percentage of persons who are eligible for cervical cancer screening. The service had recontacted the patients that had not attended by SMS text message where patients could self-book an appointment to suit them via an internet link.

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	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.	Y
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past 12 months:</p> <ul style="list-style-type: none">• An audit into a Medicines and Healthcare products Regulatory Agency (MHRA) update for the monitoring of patients prescribed Mirabegron (a medicine to treat symptoms of an overactive bladder). The service had completed 2 cycles of this audit. The process they implemented after the first audit had improved the compliance and safety for patients taking this medicine. The 2 audits were completed 11 months apart.• The service was participating in a community pharmacy referral initiative alongside a group of GP practices with the Local Pharmaceutical Committee. The initiative was still ongoing at the time of inspection.• Various single cycle audits included:<ul style="list-style-type: none">▪ A review of patient who had not completed the course of the vaccination to protect patients against shingles (a painful rash that is caused by the same virus as chickenpox).▪ A review into prescribing salbutamol inhalers (used to treat asthma) with the view to reduce the use of inhalers with a higher carbon footprint.▪ An audit of antibiotics prescribing for pyelonephritis (kidney infection) and cellulitis (a type of skin infection) and the appropriateness of the antibiotics given.	

Effective staffing

The practice was able 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.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	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.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
The practice had introduced a process to ensure staff completed 3 clinical cases to reflect on during their annual appraisal. We saw examples that this had been completed by some clinical staff members, however it had not yet been embedded for all staff.	

Coordinating care and treatment

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
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

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Partial

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. 1	Y
<p>We reviewed patients DNACPR forms and Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms during our clinical searches and during the onsite visit. We reviewed 5 patients records that were coded as having a DNACPR in place. We found patient capacity was not always documented on forms and that decisions were not regularly reviewed in line with national guidance. We also found 1 patient record that had been coded as having a DNACPR in place, which was incorrect, and the patient or GP had not agreed for a DNACPR to be in place. The practice reviewed these notes and found the cause of error. The relevant staff had learning from the incident shared and a new process had been implemented, in relation to the completion of DNACPR decisions and reviews to ensure effective care was in place for patients. However, we were not assured all patients with existing DNACPR coding would be reviewed to ensure it was appropriate or accurate.</p>	

Caring

Rating: Good

Kindness, respect and compassion
Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
<ul style="list-style-type: none"> The practice had a dedicated care co-ordination team that supported all patients including children through regular check-ins and held discussions about how the practice could best meet their needs. We were provided with examples of the care co-ordination team understanding their patients and how best to support them to access care and support. These included: A patient who was discharged from hospital following a mental health crisis was contacted by the care co-ordination team. When they were unable to get an answer and noticed routine medicine hadn't been collected by the patient, they attended the patients home. They identified that the patient was having difficulty using he phone and was experiencing extremely difficult social concerns. The team provided a personalised, caring approach to assisting the patient including support with their energy supply and access to food and hygiene. The team worked collaboratively with social services and the named GP to provide a holistic review and care. The team supported a patient with a learning disability who would not attend the GP practice to receive a blood test that was required to ensure safe care and treatment. The team attended the patient at home, allowing him to choose a safe space, provided role play of the procedure and allowed the patient to do the things he enjoyed with them. The blood test was able to be carried out in a controlled way and the results have allowed to ensure safe treatment continues. The team have been able to arrange similar visit since. 	

- A patient who was identified as vulnerable by the practice sustained an injury. The care co-ordination team and a nurse attended the property to follow up on the patients social support network and provide treatment. The patient was required to attend a follow up appointment at the practice but was planning to not attend due to how she was feeling. Due to the capacity of the clinical team, the appointment could not be changed to a home visit but the care coordination team attend the patients house and walked with the patient to and from her appointment to make sure she got the care she required and did so safely.

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	89.0%	87.4%	84.7%	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 (01/01/2022 to 30/04/2022)	87.2%	86.5%	83.5%	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 (01/01/2022 to 30/04/2022)	95.5%	94.8%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	61.3%	74.8%	72.4%	No statistical variation

	Y/N/Partial
The practice carries out its own patient survey/patient feedback exercises.	Y
The practice offered patients the chance to give feedback through the Friends and Family Test following an appointment. Feedback included: <ul style="list-style-type: none"> • Doctors providing care provided an excellent service which was well explained and informative. • Clinicians including paramedics and nurses were described as brilliant and kind. • It was difficult for patients to access practice services such as appointments through the telephone lines. Some found it easier by turning up at the practice and queuing. • Overall patient experience was very good for 72% of patients. 	

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
<ul style="list-style-type: none">The care co-ordination team supported patients where required including signposting to other organisations or following up patients themselves.	

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	93.6%	91.6%	89.9%	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.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified.	Number of carers identified: 1010. Approximately 3.7% of the patient list.
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> The practice recently achieved a gold award from their work with The Vassall Carers support centre who provide a range of service to carers locally. There was a care co-ordination team who are available to provide support to carers requiring additional support via phone or face to face. The team included a children's care coordinator for young carers. The practice signpost carers to relevant support groups such as the Alzheimer's society. Can refer patients to the social prescriber where the carer would benefit
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> Support via the care coordination team and social prescriber.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive

Rating: Good

Responding to and meeting people's needs

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

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

Practice Opening Times	
Day	Time
Opening times:	
Monday	7:30 am - 6:30 pm
Tuesday	7:30 am - 6:30 pm
Wednesday	7:30 am - 6:30 pm
Thursday	7:30 am - 6:30 pm
Friday	7:30 am - 6:30 pm
Saturdays (Pre booked remote GP cover only provided by Push Doctor)	9am- 5pm
Appointments available:	
Monday	7:30 am - 6:30 pm
Tuesday	7:30 am - 6:30 pm
Wednesday	7:30 am - 6:30 pm
Thursday	7:30 am - 6:30 pm
Friday	7:30 am - 6:30 pm
Saturdays (Remote GP cover only provided by Push Doctor)	9am-5pm

Further information about how the practice is responding to the needs of their population

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Pre-bookable appointments were available Saturdays through Push Doctor between 9am-5pm. Push Doctor is a supplementary service that provides telephone and video consultations to patients registered with the GP practice.
- The practice held a register of patients living in vulnerable circumstances including homeless people 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.
- The practice had a dedicated care coordination team to support patients. The team prioritised and supported individuals to meet their needs at outlined in the caring domain.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<ul style="list-style-type: none"> Patients were able to book appointments with a variety of clinicians including, GP's, paramedics, pharmacists or nursing team. On the day of inspection, we found there were nursing appointments available within a week. There were on the day urgent appointments available that were released at 8am each morning. There was a telephone appointment available with a paramedic for the same and next day during our visit. Patients could access the service via the telephone or online. Where the reception team had no urgent appointments left to allocate, they would seek advice from a nurse or GP. 	

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	20.1%	N/A	52.7%	Significant variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	43.0%	58.2%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	48.8%	56.9%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	66.5%	74.1%	71.9%	No statistical variation

Any additional evidence or comments

Leaders recognised patient access as one of their biggest challenges at the time of inspection. The results above are results from April 2022, since then the practice had taken the following steps to improve access, including:

- Push Doctor was used to provide supplementary GP appointments, which allow patients to book remote appointment times to suit them.
- Introduced AccuRx (communication platform) SMS text message self-book service for appointments such as chronic disease management, NHS health checks and cervical cancer screening. This service sends patients a link where they can view and select appointment times to suit their needs.
- Introduced direct lines to the medicines management team for patients with prescription related queries.
- The embedding of eConsult, which is an online form that may provide self-help advice, direct patients to a pharmacy or local self-referral services. Where an eConsult requires the attention of the GP practice, these are reviewed by the patient assistant team and directed to the most appropriate department.
- Where patients required a follow up appointment with a GP, the GP had the flexibility to book that into one of their protected appointment slots for patients with complex health needs.
- Obtained a government sponsorship licence to allow the practice to employ GP's from overseas. The practice were working towards employing their first overseas GP in Autumn 2023.
- The practice had supported staff new to practice such as nurses and staff to regain their professional registration.

The practice had begun tracking patient feedback regarding access through their friends and family test. Since April 2023, the practices own feedback findings, showed us that patient access has improved. As part the friends and family survey, patients were asked how they found the "ease of accessing the service". They found:

- In April 2023, 76.5% responded good or very good, 14.6% responded poor or very poor and the remaining responded neither.
- In May 2023, 76.1% responded good or very good, 14.8% responded poor or very poor and the remaining responded neither.
- In June 2023, 74.7% responded good or very good, 14.8% responded poor and very poor and the remaining responded neither.

The service has also monitored the complaints they have received regarding access and found that between April 2022 and March 2023 (11 months) they received 17 formal complaints relating to access. Since April 2023 (3 months) they have received 1 formal complaint about access.

Source	Feedback
NHS.uk website (formerly NHS Choices)	<p>From the feedback we reviewed we found in the past 12 months:</p> <p>73.1% of patients commenting gave the practice 4 or 5 stars. Comments included that staff were kind, caring and working cohesively, ran an efficient vaccination clinic and were supportive to carers.</p> <p>24% of patients commenting gave the practice 1 or 2 stars. Comments mostly including difficulty with access via the telephone.</p>

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	60
Number of complaints we examined.	6
Number of complaints we examined that were satisfactorily handled in a timely way.	6
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0
Out of the 6 complaints we reviewed, we found 1 where the response letter did not include signposting to the Parliamentary Ombudsman. However, we saw in all other 5 a consistent approach to managing and responding to complaints in a timely manner.	

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>The service complaints were managed by the patient experience lead. They would contact the relevant people and managers on receipt of a complaint and oversee the information gathering process. They recently recognised that the service would benefit from raising learning events for complaints alongside incidents to contribute to monitoring of the service.</p> <p>Since April 2023, where patients raised concerns, but these were resolved through a same day conversation, patients are given the option of raising this in line with the complaints policy. If the patients chose not to do this, the patient experience lead would log this as a “voice of dissatisfaction”. This allows them to monitor themes and trends that may form and contribute to learning from patient feedback.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
A family member raised concerns over a patient’s consultation including the preparedness and manner of the GP.	<ul style="list-style-type: none"> • Consent was gained from the patient and a holding letter was sent to the complainant. • The patient was booked in with another GP that specialised in the concern being discussed. • The GP involved and their team leader were informed by the patient experience lead. • The response letter was drafted by the GP involved and reviewed by the team leader. • The practice contacted the patient and was open about the incident in line with the duty of candour. • Learning was shared within the response letter and were signposted to the parliamentary ombudsman should they remain unsatisfied. • It was recognised that the clinicians would benefit from having a list of staff with specialism readily available to them, which was actioned.

Patient complained that they did not receive their video consultation within the specified time.	<ul style="list-style-type: none"> Complaint was acknowledged to the patient. Information from the team leader was requested, which found there had been a miscommunication. Staff in the relevant team were reminded of timescales they should give to patients when booking appointments. Response letter including how the issue occurred, learning and action taken. They were signposted to the parliamentary ombudsman should they remain unsatisfied.
--	--

Well-led

Rating: Requires improvement

The practice is rated requires improvement for providing a well-led service because:

- Governance processes were in place, but oversight of systems to monitor the quality of care in relation to the management of patients were not always effective. In particular, patients who were prescribed medicines that require monitoring, patients with long-term conditions and patients affected by safety alerts were not always effective .
- Leaders did not always monitor staff performance and competency to drive improvement.

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.	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.	Y
<ul style="list-style-type: none"> Most staff felt they could approach any member of the senior leadership team including the partnership team and executive managers. Leaders recognised that retaining staff and encouraging further education was important for sustainability. They had recognised that a nurse who was coming up for retirement had specialist knowledge in sexual health that would leave a gap in the team knowledge. They had supported another nurse to complete training and education in sexual health to ensure the gap was filled. 	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	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
<ul style="list-style-type: none">The senior leadership team met to discuss and develop their vision, values and strategy. Staff were not aware how they had contributed to the vision and values, but described an open culture where challenges were escalated and discussed by managers.	

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 had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>We gained staff feedback through interviews and feedback forms. Staff told us:</p> <ul style="list-style-type: none">Staff felt management was supportive and leaders were approachable.The care coordination team had set up lunchtime staff wellbeing walks.Staff were able to raise learning and incidents and reported that they felt supported to do so.Leaders aim to build an open culture and relationships with staff.	

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.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y

Managing risks, issues and performance

The practice processes for managing risks, issues and performance, however they were not always effective.

	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
<ul style="list-style-type: none">• Leaders had not always identified areas of risk or reviewed changes to systems and processes to ensure they were effective. For example, the service had implemented a process to improve the potential missed diagnosis of diabetic patients following an incident in March 2023, however we found further concerns with this during our inspection.• The practice did not have a system to actively monitor risks but used business cases to identify issues or raise areas of improvement. These were then discussed at leadership meetings to agree outcomes. Examples include:<ul style="list-style-type: none">▪ Implementation of a care navigation tool to support patient access and signposting▪ Employment of care coordinator for children's health▪ Introduction of a home visiting team.	

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
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y

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
Staff are supported to work remotely where applicable.	Y
During the COVID19 pandemic staff were supported to work remotely if needed. At the time of inspection, leaders told us they did not have any staff members that worked remotely.	

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.	N
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
The practice has had difficulty encouraging a patient led patient participation group (PPG). During the COVID19 pandemic, the PPG that the practice had in place stopped meeting. In April 2023, the practice had recontacted patients to set up a virtual PPG however, only a small number confirmed interest. The first meeting is yet to be scheduled.	

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.	Y
Learning was shared effectively and used to make improvements.	Y
<ul style="list-style-type: none">• Staff were encouraged to raise areas of improvement to leaders. Where required, the executive managers would develop business cases to take to leadership meetings. They were discussed and agreed during these meetings.• Staff and leaders were encouraged to report learning events to identify areas for improvement that would benefit patients. This resulted had resulted in changes to:<ul style="list-style-type: none">▪ Appointment length▪ Nurses appointments becoming more structured by running immunisation clinics and long term condition clinics.▪ Changes to processes or policies.	

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.
- **UKHSA:** UK Health and Security Agency.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ‰ = per thousand.