

## Inspection Evidence Table

Walsall Wood Health Centre

(1-7893012478)

**Inspection Date: 15 June 2023**

Date of data download: 22/05/2023

## Overall rating: Requires Improvement

At the last inspection in September 2022, we rated the practice as Requires Improvement overall as systems and processes were not adequate to ensure risks were mitigated and services provided to patients were well managed and ensured patients received the appropriate care and monitoring.

At this inspection although we found improvements had been made in the safe key question and governance there were some areas that required further strengthening in responsive and well-led, which we have continued to rate as requires improvement to reflect the improvements that need to be made.

## Safe

## Rating: Good

At the last inspection we rated the practice as requires improvement for providing safe services. At this inspection we have rated safe as good because we identified that improvements had been made to strengthen safety systems and processes.

### Safety systems and processes

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

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.	Y

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Since the last inspection, the practice had updated their safeguarding adult and child policies which reflected current and local guidelines and contained the name of the safeguarding lead in the practice.</li> <li>• Monthly practice meetings were held where safeguarding was a standing item on the practice meetings' agenda and concerns were discussed with staff to ensure all staff were aware of any concerns.</li> <li>• On reviewing the safeguarding register we found that alerts had been added to family members records to ensure staff were aware there was a safeguarding concern within the household. Alerts were also added to patient records to highlight safeguarding concerns.</li> <li>• The GP was the safeguarding lead and was trained to level 4. We found that all staff had completed safeguarding training, however some staff were not trained to the appropriate level for safeguarding adults and children as recommended in the Intercollegiate Guidance documents. For example, some clinical staff such as advanced nurse practitioners were only trained to level 2 for adults and children. After the inspection, the practice sent evidence to demonstrate clinicians were now trained to level 3 safeguarding for adults and children.</li> <li>• Staff files reviewed demonstrated that Disclosure and Barring Service (DBS) checks had been reviewed and were in place for staff as part of pre-employment checks. This included enhanced and standard DBS checks based on the role and responsibilities of the job. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.</li> <li>• The practice held multidisciplinary team (MDT) meetings each month. The practice told us they had attempted to engage with community teams in face to face meetings however the uptake to attend was poor, and so engagement with community teams would be done through telephone calls when required.</li> </ul>	

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
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found issues in relation to safe recruitment and no evidence to confirm staff vaccinations were maintained in line with current guidance.</p> <ul style="list-style-type: none"> <li>• At this inspection we looked at a range of recruitment files which included both clinical and administrative employed staff and found improvements had been made to staff records in line with relevant guidance.</li> <li>• We found evidence to confirm staff vaccinations were maintained in line with current guidance. Where information was not held, the practice had completed a risk assessment to identify potential risks to patients and staff. The practice told us that staff were booked in for Hepatitis vaccinations for August 2023.</li> </ul>	

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: May 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: May 2023	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Evidence provided by the practice showed equipment was regularly calibrated and electrical items were PAT (Portable appliance testing) tested.</li> <li>• Fire safety policies were in place and evidence was provided of a completed fire risk assessment.</li> <li>• The practice had carried out a range of health and safety risk assessments. An action plan was in place and evidence was provided that actions were being completed. For example: All staff had completed manual handling training due to the risk of manual lifting and the handling of equipment.</li> <li>• All staff had completed fire safety training and there were named fire marshals in place. We saw evidence of regular checks of fire alarms, extinguishers, and fire evacuation procedures. An annual risk assessment plan was in place to ensure the mitigation of risk.</li> <li>• The practice had completed assessments in place for the control of hazardous substances.</li> </ul>	

### 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: 10 April 2023	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• All staff had completed the relevant infection control training for their role through the online training system in place.</li> <li>• The practice had an infection control lead and had completed an action plan to address concerns identified during the infection control audit. For example, the flooring and seating for the consultation rooms had been replaced.</li> <li>• Policies, procedures, and audit templates were in place for infection prevention and control and were accessible for all staff. Other policies in place to support infection control included needlestick injury, hand hygiene, biological substances and waste management protocols.</li> </ul>	

- Following the last inspection, the practice had updated the Legionella testing and monthly checks were being carried out (Legionella is a term for a bacterium which can contaminate water systems in buildings).
- We observed the general environment to be clean and tidy.
- Staff we spoke with told us about the systems and processes they followed to ensure clinical specimens were handled safely.

**Risks to patients**

**The systems to assess, monitor and manage risks to patient safety needed strengthening.**

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• There was a rota in place to cover for staff absences, however we found that at times the clinical leadership was limited. The GP was not on-site on afternoons on average 3 days a week and, in their absence, the advanced nurse practitioner (ANP) provided clinical sessions without access to on-site clinical support. The practice did not use GP locums when the lead GP was absent and at times this did not mitigate any potential risks that could occur. During our inspection, the practice manager told us that the lead GP was accessible via telephone, and they were trying to recruit a GP locum to strengthen the clinical team and to provide additional cover for the GP absences.</li> <li>• The practice had a locum pack should they need to support staff working at the practice on a temporary basis.</li> <li>• Systems were in place to ensure emergency medicines and equipment was checked on a regular basis.</li> <li>• All staff had undertaken online basic life support and sepsis training and understood the procedures to follow when encountering deteriorating or unwell patients. The practice confirmed they had booked face to face basic life support training for all staff in August 2023.</li> <li>• Reception and administration staff who handled calls to the practice and arranged appointments with the clinical team were aware of potential red flag symptoms. Staff knew when to notify a GP or other clinicians with concerns.</li> </ul>	

**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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At the last inspection we identified concerns in the management of patients' medicines and a lack of clinical reviews. At this inspection, we saw improvements had been made however this work was still in progress. For example, some older patient records contained minimal information, whilst recent records we sampled were structured and adequately documented.</li> <li>The practice had a system in place for the management of referrals under the two week wait process. Monitoring processes were in place to identify patients who were referred using the two week pathway and to ensure the pathway was used appropriately.</li> <li>Regular clinical meetings were held on a monthly basis to discuss any concerns, latest clinical updates, and shared learning.</li> <li>We saw evidence of improvements to clinical oversight for non-medical prescribers working at the practice. For example, the clinical lead carried out monthly audits of consultations.</li> </ul>	

### Appropriate and safe use of medicines

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

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)	1.82	0.87	0.86	Significant variation (negative)
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)	8.3%	5.8%	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	4.95	5.19	5.24	No statistical variation

Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2022 to 31/12/2022) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	232.9‰	142.0‰	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) (NHSBSA)	1.27	0.64	0.56	Tending towards variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	13.5‰	8.8‰	6.8‰	Variation (negative)

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).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines. 1	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. 2	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England 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.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
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
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> <li>National prescribing data showed the practice prescribing was higher than local and national averages for antibiotic, hypnotics and psychotropics prescribing. The practice was aware of the higher than average prescribing and were reviewing this further. For example, we saw evidence of audits to reduce the risk of antimicrobial resistance.</li> <li>Since the last inspection the practice had implemented a non-medical prescribers' review protocol and the clinical lead was carrying out monthly audits to ensure competency standards were maintained.</li> <li>There was a system and process in place for clinical reviews and our clinical searches showed that most patients had received appropriate medicine reviews.</li> <li>As part of our inspection, we reviewed a sample of patients on Disease-modifying antirheumatic drugs (DMARDs) and high-risk medicines that required regular monitoring due to the risk of side effects. We found that most patients identified had the required monitoring in place, however for those patients prescribed methotrexate we found that the day of the week was not added to the prescription to improve safety. After the inspection the practice confirmed this had been actioned.</li> <li>During the review of the clinical system, we reviewed patients who had been prescribed Angiotensin-converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARBs) a group of medications for treating high blood pressure. We found 14 patients had not received the appropriate monitoring in the past 12 months. We sampled 5 of these patients and found that the practice was taking appropriate action to recall these patients, however 1 patient sampled required immediate action due to high blood pressure reading.</li> <li>Further reviews of the clinical system showed 51 patients were being prescribed direct oral anticoagulants (DOACs). We found all patients were up to date with the required monitoring.</li> <li>There was clinical oversight for all requests to medicine changes and a clear process was in place to demonstrate what actions had been taken.</li> <li>We found that blank prescriptions were kept securely and there was a system in place to monitor usage.</li> <li>Emergency medicines, vaccines and medical equipment were appropriately stored and there were clear monitoring processes in place.</li> <li>There were appropriate arrangements in place for the management of vaccines and for maintaining the cold chain. We saw fridge temperatures were routinely monitored and vaccines reviewed at random were in date and stored appropriately.</li> </ul>	

**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:	8
Number of events that required action:	8
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice had a significant event monitoring policy and reporting template in place. Staff we spoke with were aware of how to report and record significant events.</li> <li>Significant events were a standing agenda item at practice meetings and we saw evidence that they were discussed to share learning, best practice and give praise to staff where feedback had been positive.</li> </ul>	

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

Event	Specific action taken
Patient incorrectly diagnosed and called the practice to query this further.	The practice looked into the concerns raised and identified their error. This information was discussed with the patient and the practice identified a further training need for the staff member involved.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The provider had a process and system in place to action safety alerts, however following our review we did find that for one patient there was a delay in reviewing this in a timely way.</li> </ul>	

## Effective

## Rating: Good

At the last inspection we rated effective as requires improvement as we found that patients' care and treatment was not regularly reviewed and updated. At this inspection we have rated effective as good because we found that those areas previously regarded as requiring improvement had improved.

*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 delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>The practice had systems to keep clinicians up to date with current evidence-based practice and whilst we found that improvements had been made since the last inspection, there were still areas that required improving in line with national guidance. For example: we were unable to evidence that patients were issued with steroid cards following an asthma exacerbation and some records lacked detail regarding safety netting.</li></ul>	

## Effective care for the practice population

Findings
<ul style="list-style-type: none"><li>Those identified received an assessment, however whilst some reviews were structured, other reviews lacked structure and safety netting in line with national guidance.</li><li>Health checks, including frailty assessments, were offered to patients over 75 years of age.</li><li>Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.</li><li>The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.</li><li>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.</li></ul>

- All patients with a learning disability were offered an annual health check. The practice had carried out 50% of learning disability review in the last 12 months.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- 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. The practice had carried out 84% of mental health reviews in the last 12 months.

## Management of people with long term conditions

### Findings

- We found that improvements had been made for the monitoring of long term conditions since the last inspection, however some records varied. For example, some clinical records contained minimal information and did not demonstrate that a structured annual review was being carried out to check their health and medicines needs were being met, whilst recent reviews contained structured information.
- We found there were 7 patients prescribed 2 or more courses of a steroid medicine for their asthma. We sampled 5 patient records and found 4 of these patients were appropriately managed at the time of their asthma exacerbation (attack) and they had received a review in the previous 12 months. However, we found that these patients were not offered a steroid card and the clinical notes lacked detail regarding the safety netting as part of best practice.
- We reviewed records of patients with later stage chronic kidney disease and found that appropriate monitoring was in place.
- We randomly reviewed the records of five patients with hypothyroidism. The records showed that monitoring was in place, however the medication reviews lacked detail and structure.
- We reviewed the records for five patients with diabetic retinopathy (a complication of diabetes) and four patients were up to date with monitoring, however for one patient a further review was needed. After the inspection the practice confirmed they would review this further.
- Patients with long-term conditions were offered an 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.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- 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%
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The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenzae 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)	17	18	94.4%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	19	20	95.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	20	20	100.0%	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)	20	20	100.0%	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)	18	19	94.7%	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)	61.4%	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)	60.4%	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)	79.6%	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)	44.4%	48.3%	54.9%	No statistical variation
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### Monitoring care and treatment

**The practice had a 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
Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:  The practice had carried out a range of reports and audits. This included: <ul style="list-style-type: none"> <li>• A two cycle audit for the prescribing of Amiodarone &amp; Dronedarone.</li> <li>• Antibiotic prescribing audits.</li> <li>• An audit for the monitoring of patients prescribed Novel/Direct Oral Anticoagulants.</li> <li>• 2 week wait referrals audits.</li> <li>• PINCER audits were carried out which included, for example, prescription of an oral NSAID, without co-prescription of an ulcer healing drug, to a patient with a history of peptic ulceration, Prescription of aspirin in combination with another antiplatelet drug without co-prescription of an ulcer-healing drug, prescription of lithium without recent lithium blood test and prescription of a non-selective beta-blocker to a patient with a history of asthma.</li> </ul>	

### 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.	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.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Staff had access to and completed training identified as mandatory by the provider, however we found that some clinical staff were not trained to the appropriate levels for their roles. For example, the advanced nurse practitioner was not trained to safeguarding level 3 and was working unsupervised at the practice.</li> <li>• There was oversight of training which was monitored by the management team to ensure all staff were up to date with their training needs.</li> <li>• Training records seen demonstrated that staff in extended roles had received appropriate role specific training for the work they performed. For example, we saw evidence that the nurse was up to date in training such as cytology, immunisations, diabetes and sexual health.</li> <li>• At this inspection, we were able to evidence oversight for non-medical prescribers through audit of their consultations. The practice had recently introduced a non-medical prescribers' protocol, however this had been recently introduced and needed time to be embedded.</li> <li>• We found that staff appraisals had been completed and development opportunities were discussed with staff members as part of this process. For example, a receptionist was in the process of training as a health care assistant as part of their development.</li> </ul>	

### 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice website detailed information and links for health promotion, for example, health conditions and common health questions.</li> </ul>	

### Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence	
<ul style="list-style-type: none"> <li>Training records showed that all staff had completed training relating to the Mental Capacity Act and Deprivation of Liberty Safeguards.</li> <li>Staff we spoke with had an understanding of relevant legislations and guidance when obtaining consent and decision making and had access to policies and procedures to support them.</li> </ul>	

## 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Staff understood the needs of the population and had received appropriate training in providing a chaperone service as well as promoting equality and diversity.</li> </ul>	

### 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)	77.8%	79.0%	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)	78.6%	76.9%	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)	91.0%	89.5%	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)	79.6%	62.3%	72.4%	No statistical variation

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

### Any additional evidence

The practice was in line or above local and national averages for patient satisfaction in relation to caring. Although the practice did not carry out its own patient surveys, it did have a patient participation group (PPG) where areas of improvements was discussed.

### 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Although there was no hearing loop available at the practice, staff told us that patients were flagged on the system to ensure they were given access to the right support when attending appointments.</li> </ul>	

Source	Feedback
Interviews with patients.	We spoke with two patients during the inspection process. They told us they were well cared for, listened to and all the staff explained everything clearly.
CQC Observations	We saw staff were helpful in their approach towards patients when taking calls and when patients attended the practice in person.

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)	92.9%	85.2%	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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Interpreting services were available for patients if required.</li> <li>Since the last inspection the practice had updated their website to enable patients with other languages to access the information easily if they required advice.</li> </ul>	

Carers	Narrative
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Percentage and number of carers identified.	The practice had 77 carers on their register. This represented 4% of the practice list.
How the practice supported carers (including young carers).	Carers were offered the flu vaccination and annual health checks.
How the practice supported recently bereaved patients.	The practice called the families to offer support and advice.

### 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Staff recognised the importance of and took measures to ensure people's dignity and respect when using the service.</li> <li>Staff knew that if patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs. There was information at reception alerting patients to this.</li> </ul>	

## Responsive

## Rating: Requires Improvement

At our last inspection we rated the practice as requires improvement for providing responsive services. At this inspection that rating remains requires improvement because we continued to identify a shortage of appointments with clinical staff and people were not always able to access care and treatment in a timely way.

### Responding to and meeting people's needs

**The practice organised and delivered services, but they did not always meet patients' needs.**

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>We reviewed appointment availability as part of our inspection and found that at times there was limited appointment availability with a GP. For example, only one GP was employed by the practice, and was not available for afternoon sessions on average 3 days per week. There was no GP locum cover, and other clinical staff provided appointments for patients when the GP was not on-site. This did not assure us that patients were given flexibility for appointments or that patients were able to see a GP in a timely way.</li> <li>On reviewing the appointment system, we found on some days only 5-6 appointments were offered to patients with the GP. Whilst we could evidence extra appointments had been added, the lack of GP availability did not always meet patients' needs.</li> <li>As part of the primary care network, the practice had a paramedic and physiotherapist who provided weekly sessions to increase the services available.</li> </ul>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	7.30am – 6.30pm
Tuesday	8am - 7pm
Wednesday	8am – 1pm
Thursday	8am - 7pm
Friday	8am – 6.30pm
Appointments available:	
Monday to Friday	<p>Appointments were available at various times according to the clinician. Extended hours appointments were available on Tuesday and Thursday evening until 7pm.</p> <p>On Wednesday afternoons when the practice is closed cover is provided by Ournet and out of hours services provided by NHS111.</p>

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> <li>Patients had a named GP who supported them in whatever setting they lived.</li> <li>The practice was not always able to demonstrate they were responsive to the needs of patients as the GP provided appointments three times per week. We were told the GP was available if needed to provide urgent appointments for those with enhanced needs and complex medical issues and home visits were carried out as required.</li> </ul>

- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- Nurse appointments were available on Tuesday afternoon until 5.40pm for school age children so that they did not need to miss school.
- The practice was open at 7.30am on Mondays and until 7pm on a Tuesday and Thursday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a primary care network. Appointments were available Saturday and Sunday 10am until 1pm.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people. The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

**Access to the service**

**People were not always 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.	Partial
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.	Partial
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Since the last inspection we still found concerns in the availability of GP appointments. For example, the GP was not available 3 afternoons per week and there were no services available to patients on those days, except appointments with the practice nurse and advanced nurse practitioner. Whilst the practice was working to address the shortfalls and working with locum agencies to recruit a further GP in the GP's absence, we found that this was impacting on offering services that met patients' needs.</li> </ul>	

**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
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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)	79.1%	N/A	52.7%	Significant variation (positive)
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)	69.7%	46.1%	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)	61.4%	48.6%	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)	60.6%	64.8%	71.9%	No statistical variation

Source	Feedback
Patient interview	We spoke with a patient who told us it was difficult to get an appointment to see the GP as they were never available at the practice.
NHS UK	Feedback reported difficulties in getting an appointment and hard to see a GP face to face.

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

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

Example(s) of learning from complaints.

Complaint	Specific action taken
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Patient complained that they did not want to explain to receptionist the reasons for their appointment.	The practice looked into the concerns and explained the triage process when calling into the practice.
Patient complained about the delay in waiting for an appointment following a referral made.	The practice looked into the concerns raised and agreed to make a further referral to another hospital.

## Well-led

## Rating: Requires Improvement

At the last inspection we rated the practice inadequate for providing well-led services because the leadership team demonstrated a lack of governance oversight and processes to effectively drive improvement.

At this inspection we have rated well-led as requires improvement as systems and processes had been reviewed but some areas required further strengthening to ensure risks were mitigated.

### Leadership capacity and capability

**Leaders could not always demonstrate that they had the capacity and skills to deliver high quality sustainable care.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Since the last inspection we saw evidence that processes had been reviewed for safe and effective care, however we found that the quality and sustainability needed further review as we did not feel assured there was adequate access of a GP throughout the week which impacted on patients receiving timely care and treatment.</li> <li>• The leadership team were aware of the challenges and were reviewing this to ensure sustainability of the service. This included discussions with other providers to look at future provision of the service and recruit more GPs, however this needed embedding further to ensure that resources and future provision were achievable and sustainable.</li> <li>• Staff we spoke with explained that the leadership team were visible and approachable. Staff described the practice team as supportive.</li> </ul>	

## Vision and strategy

**The practice had a clear vision, but this needed embedding further 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.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The vision of the practice was to move premises as these were small, however this was still being explored as a viable option.</li><li>• The practice had a strategy, and the succession planning considered the joined up working with other practices and increasing the availability of clinical staff to meet the patient population, however this had recently been developed.</li><li>• Regular staff meetings were in place. Changes were discussed and shared with staff during these meetings.</li></ul>	

## 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.	Partial
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
Explanation of any answers and additional evidence: <p>Since our last inspection the practice had made improvements in the culture, however some areas required further improvements. For example:</p> <ul style="list-style-type: none"><li>• Policies and procedures had been updated and were accessible to staff, for example, infection control, safeguarding and health and safety.</li></ul>	

- The practice had whistleblowing and duty of candour policies in place and a nominated freedom to speak up guardian to support staff if they wanted to raise an issue.
- We looked at a sample of training records and all staff had completed equality and diversity training.
- All staff had received an annual appraisal within the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Practice meetings took place which provided an opportunity for staff to discuss issues.
- All the staff we spoke with told us that they felt supported by management and leaders, however the lead GP was not onsite 3 afternoons per week and some clinicians told us that having more clinicians would enable them to have more administrative time.
- There was an open culture and clear learning within the practice. The management team and leaders encouraged the reporting of incidents to identify ways in which the practice could continually improve.

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

Source	Feedback
Staff interviews	Managers are approachable and supportive. Everyone tries and supports each other. It's a small practice and we all get on and communicate well.

**Governance arrangements**

**There were clear responsibilities, roles and systems of accountability to support good governance and management, however this needed to be embedded.**

	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
<p>Explanation of any answers and additional evidence:</p> <p>Since our last inspection, we had seen improvements in the overall governance and management, however some processes were newly established or needed further review to ensure they were embedded and safe and effective.</p> <ul style="list-style-type: none"> <li>• The practice was able to demonstrate that some improvements had been made to the oversight of governance arrangements to ensure risks to patients were considered, managed and mitigated; however, we continued to find gaps in some areas. For example, some clinicians were not trained to appropriate safeguarding levels for their role.</li> <li>• Governance processes had been reviewed; however, we were not assured of the processes in place for staff when the GP was on leave and could not be assured that the arrangements in place mitigated risk.</li> <li>• The practice had policies in place to support staff within their roles. The policies contained clear information about the designated lead in areas such as infection, prevention and control and safeguarding. All staff were aware of the designated leads in these areas.</li> </ul>	

- Policies and procedures had been reviewed and were in place to ensure safety reflected the latest guidelines. For example: repeat prescribing protocol, health & safety policy and non-medical prescribers' protocol.
- Staff recruitment and personnel files had been reviewed to reflect best practices in line with safer recruitment.

**Managing risks, issues and performance**

**There were clear and effective processes for managing risks, issues and performance but further work was needed to mitigate all risk identified.**

	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.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice undertook a range of risk assessments, for example, health and safety, fire safety and equipment calibration and infection control. These were carried out to ensure risks were identified, managed and improvements made to mitigate the level of risk.</li> <li>• Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs; however, we did not feel assured that this was sufficient to meet the needs of the service. For example, a GP was not available 3 afternoons per week and in their absence an advanced nurse practitioner provided clinical care. During our inspection, the practice told us they were trying to source GPs to provide clinical sessions.</li> <li>• There was a programme of clinical auditing in place to monitor quality and implement improvements.</li> <li>• There was a business continuity plan in place and staff had been trained on how to respond to incidents such as medical emergencies.</li> </ul>	

**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
<p>Explanation of any answers and additional evidence:</p>	

- The practice could evidence they had systems and processes to review information and performance. This included the use of the Quality and Outcomes Framework (QOF), audits and action plans to improve clinical performance and outcomes for patients.
- On reviewing a sample of patients' clinical records, we found since the last inspection improvements in the reviews and monitoring of patients' conditions.

## 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice used NHS approved software when consulting with patients remotely.</li> <li>• Staff had received training and had access to guidance when undertaking remote consultations and had policies to support them on information governance.</li> </ul>	

## Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice had a patient participation group (PPG) and we saw evidence that two meetings had been held in the last 6 months. Through discussions with the PPG there were plans to host a Macmillan coffee morning during the flu campaign.</li> </ul>
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**Continuous improvement and innovation**  
**There were 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice made use of incidents and complaints to improve the service.</li> <li>The practice had reviewed their systems to monitor the quality of its services and to ensure patients were prioritised for reviews and monitoring.</li> </ul>	

**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
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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.