

Inspection Evidence Table

Meadowbrook Surgery

(1-569626952)

Inspection Date: 14 September 2023

Date of data download: 05/09/2023

Overall rating: Requires Improvement

We have rated the practice requires improvement overall because:

- The practice did not always have systems for the appropriate and safe use of medicines, including medicines optimisation.
- Patients’ needs were not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance.
- There were clear responsibilities, roles and systems of accountability to support good governance and management. However, improvements were required.

Safe

Rating: Requires Improvement

We have rated safe as requires improvement because:

- We found there was a lack of oversight for safeguarding registers.
- We identified potential missed diagnoses and coding issues for patients with chronic kidney disease.
- We saw evidence that some medicine safety alerts were not actioned in a timely way.

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.	Y
There was active and appropriate engagement in local safeguarding processes.	Y

The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had systems in place to safeguard children and vulnerable adults from abuse. This included updated policies and procedures, which were accessible to all staff on the practice shared drive. • The practice had a designated safeguarding lead in place to manage and support the safeguarding of adults and children. • All staff received safeguarding training and staff records showed that clinical and non-clinical staff had completed training which was appropriate to their role. Staff had completed Identification and Referral to Improve Safety (IRIS) training. IRIS is a training and support programme developed to enable health staff to identify patients affected by domestic violence. Completion of the programme enabled the practice to be registered as an IRIS practice. • All staff knew how to identify and report safeguarding concerns. Practice staff were able to share examples of suspected safeguarding and how these were reported. • Alerts were put on the records of patients identified as being at risk from abuse and this was discussed in practice meetings; however, we were unable to establish that the practice were actively reviewing safeguarding registers and removing patients from the list once appropriate. During our inspection the practice told us that safeguarding registers would be actively reviewed and updated on a monthly basis. • The practice worked with other agencies to support patients and protect them from neglect and abuse. For example, the practice nurse contacted health visitors and had access to a midwife who attended the practice weekly. • Clinicians followed up children and young people who were not brought to their appointments both at the practice and for secondary care appointments. 	

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> <ul style="list-style-type: none"> • We found that recruitment checks had been carried out in line with safer recruitment and all staff had a DBS in place, however three non-clinical staff members did not have a documented risk assessment to explain why a recent DBS was not required. The practice took action to complete this during our inspection. 	

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: October 2022	Y
There was a fire procedure.	Y
Date of fire risk assessment: 29/10/2022	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"> • Staff had access to a health and safety policy, which had been reviewed in the last 12 months. • The practice had carried out a health and safety and premise risk assessment in October 2022. Areas of health and safety included slips, trips and falls, manual handling, chemicals risk assessment, consulting room assessments and a visitors and security risk assessment. • A fire risk assessment had been carried out and fire extinguishers checks had been reviewed in August 2023. We saw evidence that fire alarm testing was checked on a weekly basis. • An air and water risk assessment had been carried out for the building in October 2002 and gas safety checks were completed in September 2023. • Calibration checks for equipment was undertaken in November 2022 and testing of portable appliances was undertaken in October 2022 to ensure they were fit for purpose and were in good working order. • Training records showed that not all staff had completed fire safety or health and safety training. For example, 10 out of 13 staff's fire training was out of date. 	

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.	Partial
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: 02/03/2023	Y
The practice had acted on any issues identified in infection prevention and control audits.	Partial
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"> • We found that all staff with the exception of 1 member had completed their training for infection, prevention and control. • There was an infection control lead in place and an infection control audit had been carried out in March 2023 and the overall score was 75%. The audit identified a number of areas. For example, issues with high and low dust, posters required to aid staff around IPC measures, replacing blood pressure cuffs and relocating minor surgery due to the lack of facilities available in the room that is being used. At the time of our inspection the practice were working to address the areas highlighted. 	

Some of these had already been actioned, however other work such as replacing sinks were still to be addressed.

- We found that sharps bins were signed and dated and stored appropriately in clinic rooms.
- Other policies such as biological and clinical waste, needlestick injury, safe use and removal of sharps and control of substances hazardous to health (COSHH) were in place to support infection control.
- Staff we spoke with told us about the systems and processes they followed to ensure clinical specimens were handled safely.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
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"> • A rota system was in place to manage staffing. At the time of our inspection, the practice was recruiting a further receptionist and a healthcare assistant. • The practice told us that they rarely used locum GP's, however a locum pack was in place should they need to employ staff on a temporary basis. • Staff had not completed sepsis training (sepsis is the body's extreme response to an infection, which is a life-threatening emergency), however, reception staff told us when they would notify a GP or other clinicians with concerns. • Systems were in place to ensure emergency medicines and equipment was checked on a regular basis. • Staff had completed basic life support training and all staff had undertaken cardiopulmonary resuscitation (CPR) and anaphylaxis training in February 2023 and understood the procedures to follow when encountering deteriorating or unwell patients. 	

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"> • During our review of patient records, we found inconsistencies in the documenting of some care records. For example medicine reviews contained limited information and we found that some patients records had not been appropriately coded. For example, we reviewed a sample of 5 records and found that 3 records had insufficient information. For example, some clinical staff had not maintained accurate, complete, and contemporaneous records in respect of each patient, and of decisions taken in relation to the care and treatment provided. • Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance. • There was a system in place to ensure all patient information including documents, laboratory test results and cytology reports were reviewed and actioned in a timely manner. • We found that test results were managed in a timely way and all workflow was followed up and actioned appropriately. 	

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) (01/07/2022 to 30/06/2023) <small>(NHSBSA)</small>	1.20	0.92	0.91	Tending towards 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). (01/07/2022 to 30/06/2023) <small>(NHSBSA)</small>	9.6%	5.7%	7.8%	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	6.18	5.25	5.24	Tending towards variation (negative)

uncomplicated urinary tract infection (01/01/2023 to 30/06/2023) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	102.5‰	143.0‰	129.5‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.78	0.62	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	5.2‰	9.0‰	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).	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.	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.	Partial
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	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"> • The practice had a higher than national average of antibiotic use and had identified reasons for this. For example, there was a high prevalence of urinary tract and other infections due to an older population and providing services to a care home, with patients diagnosed with learning disabilities. At the time of our inspection the practice was working to reduce their use of antibiotics prescribing through a pilot in conjunction with the integrated care board. • We completed a series of searches on the practice’s clinical records system. These searches were completed with the consent of the provider, and to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance. • During the review of the clinical system, we reviewed patients who had been prescribed methotrexate (a disease modifying anti-rheumatic drug prescribed in the treatment of rheumatoid arthritis). We found potentially 16 patients had not had the required monitoring in the last 6 months. We reviewed a random sample of 5 clinical records and found all 5 patients had the appropriate blood monitoring in place, however the medicines prescribed did not specify which day of the week the patient should take their medicines in line with NICE guidance. • We found that 155 out of 339 patients over the age of 70 years were prescribed nonsteroidal anti-inflammatory drugs (NSAID) or antiplatelets with no proton pump inhibitors (PPI). PPI’s reduce the risk of gastrointestinal bleeding caused by the medicines. We sampled 5 records and found that 1 patient was at potential risk of gastrointestinal bleed as a PPI was not given with the nonsteroidal anti-inflammatory drug (NSAID) or antiplatelet agent. • We reviewed patients who had been prescribed medicines to treat hypertension and found potentially 216 had not had the required monitoring. We reviewed a random sample of 5 clinical records and found 3 were overdue monitoring and had not had an updated urea and electrolytes test since 2019. • We reviewed patients with chronic kidney disease (CKD) 3, 4 and 5 and our searches identified potentially 85 patients with a missed diagnosis. We sampled 5 records and found that all 5 had a misdiagnosis of CKD 3. • We looked at patient group directives (PGDs - a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber). We saw that they had been authorised appropriately. • We found that blank prescriptions were kept securely and there was a system in place to monitor usage. • Emergency medicines, vaccines and medical equipment were appropriately stored and there were clear monitoring processes in place. • 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. 	

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:	4
Number of events that required action:	4
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. • Significant events were a standing agenda item and we saw evidence that they were discussed at clinical meetings and practice meetings. 	

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

Event	Specific action taken
The incorrect test form was carried out for a patient in error.	The test was repeated, and the practice investigated the error. Learning was carried out to ensure staff complete the correct forms when samples are sent to the laboratory in line with their policy.
Request for a home visit was not carried out in error.	The practice investigated the error and found that the request for a home visit was not documented and there was a lack of audit trail. The home visiting policy and documenting of home visit requests were reviewed with staff to ensure there is a clear audit trail for requests.

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had a system in place to review and action safety alerts, however we were not assured that these were always followed up and actioned in a timely way. For example, as part of our clinical searches we reviewed an alert for a medication to treat the symptoms of an overactive bladder due to the increased risk of hypertension and found that 11 out of 25 patients were identified as having no blood pressure monitoring in the last 12 months. We sampled 5 patients records and found that 3 out of the 5 patients were overdue monitoring and 2 of these patients had not had a recorded blood pressure reading 2018. 	

Effective

Rating: Requires Improvement

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 but 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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had systems to keep clinicians up to date with current evidence-based practice, however we found that some areas of medicines management required strengthening. For example, some patients were not coded on the system correctly; and we found that others who had a misdiagnosis for chronic kidney disease had not been followed up appropriately. Searches of the clinical system showed 52 patients with asthma had been prescribed 2 or more courses of rescue steroids in the past 12 months. We reviewed a random sample of 5 patients and found the practice had not followed recommended guidelines and followed up patients after being prescribed steroids following an asthma exacerbation. We found that some of the required blood test monitoring for patients with long-term conditions had not always been completed within a timely manner. 	

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, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- There was not always 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. The practice had completed 69% of learning disability reviews 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 was currently registered as dementia friendly.

Management of people with long term conditions

Findings

- Most patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. However, on reviewing the clinical system we found 12 patients with chronic kidney disease stage 4 or 5 who had potentially not received the appropriate monitoring in the past 9 months. We reviewed a random sample of 5 patients and found 2 patients had not received appropriate monitoring and their records needed their diagnosis updating from stage 3 to stage 4.
- Our clinical searches found 345 patients with hypothyroidism and we identified 81 patients who had potentially not had the appropriate monitoring in the past 18 months. We reviewed a random sample of 5 patients' and found 4 patients were overdue medicine reviews and all 5 had not received the appropriate monitoring such as thyroid stimulating hormone test (TSH).
- We found there were 44 patients with diabetic retinopathy who's latest HbA1c was above 74mmol. We reviewed a random sample of 5 patients and found 1 out of 5 patients was overdue a medication review and this had not been coded in the last 12 months. The practice employed a diabetic nurse two days per week who worked in conjunction with the GP to provide diabetic clinics at the practice. The practice also attended diabetic MDT meetings with secondary care services.
- Following the inspection, we received evidence to demonstrate that the practice was reviewing each patient we had identified through the clinical searches.
- 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.
- 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/,) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	60	60	100.0%	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)	49	50	98.0%	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)	49	50	98.0%	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)	49	50	98.0%	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)	62	67	92.5%	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)	73.6%	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)	74.5%	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). (3/31/2023 to 3/31/2023) (UKHSA)	78.7%	N/A	80.0%	Below 80% target

Any additional evidence or comments

The practice had appointed two cancer champions and the nurse could evidence that annual audits were undertaken for cervical screening.

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: <ul style="list-style-type: none"> Clinical audits in relation to antibiotic prescribing had been undertaken by the practice. The aim of the audits was to reduce the overall antibiotic prescribing for adults and children with a specific focus on reducing Co-amoxiclav, Cephalosporin and Quinolone prescribing, reducing the duration of treatment and reducing Trimethoprim prescribing. Audits had been carried out for amoxicillin, and urinary tract infections to consider the course length, quantity, rationale for prescribing the medicine and whether an alternative could have been offered. The action plan remained ongoing and focused on areas such as the delay of prescriptions where appropriate and to provide literature to patients regarding antimicrobial stewardship. Other audits the practice had undertaken included: chronic obstructive pulmonary disease (COPD), joint injections and medicines management that required monitoring (DMARDS and DOACS). 	

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.	Partial
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"> • The practice had a programme of learning, which was monitored by the management team, however not all staff were up to date with their mandatory training requirements. • Clinical staff had opportunities to attend local networks and online events to help maintain their skills and development. • We found that staff appraisals had been completed and development opportunities were discussed with staff members as part of this process. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Systems were in place to share information about patients electronically with other services. • We saw evidence of regular staff meetings to ensure staff were kept up to date with guidance and best practice. • The practice were not part of the primary care network but had access to services within it. The practice attended MDT meetings within the locality to coordinate care and review unplanned admissions. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice shared relevant information with out of hours services to support continuity of care. • We saw evidence of staff meetings to ensure staff were kept up to date with guidance and best practice, however the nursing team were not part of practice or clinical meetings but had access to clinicians and minutes of those meetings if required. • The practice attended MDT meetings across the locality which were attended by other practices and professionals where appropriate for example, district nurses, social services, care coordinators and the palliative care team. • The practice were not part of a primary care network, but had access to services within the local area. This included: phlebotomy, listening and guidance, dieticians, dementia and frailty team, health and wellbeing coach, care coordinators, and first contact practitioner. 	

Consent to care and treatment

The practice 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.	Partial
<p>Explanation of any answers and additional evidence:</p>	

- We reviewed 2 DNACPR decisions that was in place for patients whilst in secondary care. These had been documented in the patient records; however, we were unable to evidence that these had been reviewed further with patients following a discharge in secondary care. After our inspection, the practice told us that action had been taken to code DNACPR registers and they will be reviewed on a monthly basis to ensure that decisions were made in line with current legislation and appropriately recorded.

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"> Staff we spoke with demonstrated the values of the practice and dealt with patients with kindness, respect, and compassion. Interactions we observed between staff and patients, showed that staff listened to patients and treated them with kindness. 	

Patient feedback	
Source	Feedback
Patient interviews	We spoke with four patients during our inspection who were all positive about the practice. Patients told us that staff were superb and helpful. They felt involved in the decisions about their care, they were given enough time during their appointments and would recommend the practice to others.
Care home	We gathered feedback from a care home the practice provided services to. Feedback reported that there was a named GP attached to the practice who worked well with their patients and had an understanding of their needs.

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 (01/01/2023 to 30/04/2023)	91.9%	78.8%	85.0%	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 (01/01/2023 to 30/04/2023)	88.6%	77.2%	83.8%	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 (01/01/2023 to 30/04/2023)	97.3%	89.5%	93.0%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	77.5%	61.1%	71.3%	No statistical variation

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

Any additional evidence
<ul style="list-style-type: none"> Although patient outcomes in relation to caring were above local and national averages the practice continued to analyse data and carry out their own patient survey to improve patient satisfaction. This included continuing to improve the customer service experience for patients at the practice. The practice continued to gather and analyse data from NHS Friends and Family Test (FTT) and were able to evidence that 94% of patients find the overall experience of our service very good or good.

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"> Resources were available such as language line and a hearing loop for patient support. 	

- Staff we spoke with were aware of the needs of the practice's population and gave us examples on how they supported patients. For example, appointments were offered at different times of the day to suit patients needs and longer appointments were available for patients with complex needs.

Source	Feedback
Interviews with patients.	We interviewed four patients, who all told us they were able to make an appointment with a GP of choice, the clinician listens and understood their wishes and they felt involved in decisions about their care and treatment.

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 (01/01/2023 to 30/04/2023)	93.3%	85.3%	90.3%	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:	

Carers	Narrative
Percentage and number of carers identified.	The practice had 179 patients who were registered as carers which was 2.6% of the practice population.
How the practice supported carers (including young carers).	Carers were offered a flu vaccination and signposted to services for additional support if required.
How the practice supported recently bereaved patients.	Patients were signposted to bereavement support services if they required additional support.

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"> • Staff recognised the importance of and took measures to ensure people’s dignity and respect when using the service. • Staff knew that if patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs. • We saw there were chaperone signs on display and the practice had baby changing facilities. 	

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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice were aware of their population and worked with other practices and services to offer flexibility and to understand patient needs and develop services for their local population. • There were arrangements in place for interpreting services should patients request this. • The practice had been adapted for wheelchair access and had a ramp and handrails in place. 	

Practice Opening Times

Day	Time
Opening times:	
Monday	8.30am - 6pm
Tuesday	8.30am - 6pm

Wednesday	8.30am - 6pm
Thursday	8.30am - 12pm
Friday	8.30am - 6pm
Appointments available:	
Monday	GP's: 8.30am – 11.30am and 3pm – 6pm Nurse: 9am – 12.30pm and 2.30pm – 5.30pm
Tuesday	GP's: 8.30am – 11.30am and 3pm – 6pm Nurse: 9am – 12.30pm and 2.30pm – 5.30pm Diabetic nurse: 9am – 5.45pm
Wednesday	GP's: 8.30am – 11.30am and 3pm – 6pm Nurse: 9am – 12.30pm and 2.30pm – 5.30pm Diabetic nurse: 9am – 2pm
Thursday	GP's: 8.30am – 11.30am Afternoon: Practice Closed
Friday	GP's: 8.30am – 11.30am and 3pm – 6pm
<p>The practice did not provide extended access; however, patients could access appointments from practices within the Halesowen PCN: Monday to Friday 6.30pm until 8.30pm and Saturday's 8am until 12pm.</p> <p>The practice commissioned an out of hours provider when the practice was closed: Monday to Friday between 8am and 8.30am and 6pm and 6.30pm and Thursday's 12pm-6.30pm.</p>	

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 with the community services to discuss and manage the needs of patients with complex medical issues.
- Nurse appointments were available until 5.30pm on a Monday, Tuesday and Wednesday for school age children so that they did not need to miss school. All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Pre-bookable appointments were available to all patients at additional locations within the area. Appointments were available on Saturday's 8am until 12pm.
- The practice held a register of patients living in vulnerable circumstances including mental health and those with a learning disability. Longer appointments were offered to patients to meet their needs.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice employed a diabetic nurse, two days per week who worked in conjunction with the GP to offer diabetic clinics.

- Patients registered at the practice could access a phlebotomy service, first contact physiotherapy service, social prescribers, health and wellbeing coach, dementia and fragility team and dietician services.
- The practice was awarded the Armed Forces Veteran Friendly accreditation and dementia friend's status.
- At the time of our inspection the practice was recruiting a health care assistant.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Accessible and urgent appointments were made available to children and patients assessed as vulnerable. We saw evidence of appointment slots available throughout the day for patients the practice deemed as a priority. • Patients were able to access appointments face-to-face, by phone and through the practice website. We saw from the appointment system that face-to-face; video and telephone consultations were available to book in advance with a named GP or on the day with a duty GP. The practice also used an online consultation service through their website. • The practice had a daily duty GP who was able to manage urgent appointments on the day. • Patients were able to request repeat medication by telephoning a dedicated phone line or requesting this on the practice website, or through the NHS app. • Patients with dementia, mental health and a learning disability were offered longer appointments. • Appointments suitable for working patients were available at the practice and through arrangements with the primary care network (PCN) and extended services where appropriate. • Interpreter services were available for patients who did not have English as their first language. • The practice regularly reviewed capacity and demand. For example, an increase in book on the day appointments are offered during the winter period. • Flu clinics were offered to patients during evening and weekend appointments. • The midwife held weekly appointments at the practice. • Although the practice were in line with local and national averages in relation to responsive, they had an action plan in place to improve further on access. For example, they were continuing to promote 	

the practice website and NHS app and were using a health check questionnaire as part of a healthcare assessment.

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 responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023)	53.8%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	52.8%	44.4%	54.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	54.9%	46.5%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	63.4%	65.9%	72.0%	No statistical variation

Source	Feedback
NHS.uk website (formerly NHS Choices)	There were 3 reviews on NHS UK in the last 12 months. Two patients reported difficulties in getting an appointment, whilst another reported that staff were very friendly and where possible will everything to get you the right advice and appointments.
Patient interviews	We spoke with four patients who told us that were able to make an appointment, however this has been more difficult since the pandemic. For example, a patient waited two weeks to see a named GP.
Care Home	We spoke with a learning disability care home registered with the practice. Feedback reported that patients were offered an annual review and overall the practice supported patients, however at times they had experienced difficulties in getting an appointment for their patients.

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.	4
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	4
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient complained about how staff dealt with a query regarding an appointment and medication.	The practice apologised to the patient and investigated the complaint. The process was reviewed to ensure the duty GP is informed of prescription queries. A review of the appointment system was undertaken to meet patient demand when requesting pre-bookable appointments.
Patient complained about the poor attitude of staff member on the telephone.	The complaint was investigated, and the recording of the call was reviewed. The patient was offered an apology and training and learning was reviewed with the staff member on customer service.

Well-led

Rating: Requires Improvement

We have rated well-led as requires improvement because:

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

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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice had an experienced leadership team in place, who understood the challenges to healthcare. • There were regular documented clinical, practice and management meetings so leaders could demonstrate discussions around challenges and succession planning. • Staff members we spoke to told us that leaders were visible, supportive and approachable. • The practice was responsive and proactive to feedback during the inspection process and acted upon our findings and feedback. 	

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.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice vision was to deliver a high quality safe and patient centered service with an emphasis on care, compassion and respect for everyone. • The practice measured their progress against benchmarks, for example, The Dudley Quality Outcomes for Health Framework (DQOFH), medicine audits and patient satisfaction. 	

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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff members we spoke to said they were able to speak to management to report any issues, if required. • Feedback from staff during the inspection was that they felt positive about working at the practice. • Staff told us that if they were to raise a concern, they felt it would be welcomed. • There was a whistleblowing policy and a duty of candour policy in place. • The practice had access to a Freedom to Speak Up Guardian. Staff were aware of who this was. • We saw that whistleblowing and equality and diversity training were part of the mandatory training schedule, however not all staff were up to date with this training. 	

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

Source	Feedback
Staff interviews	Feedback from staff told us that they enjoy working at the practice, staff are approachable, kind, supportive and it is a happy place to work.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management, however some areas needed strengthening.

	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> <ul style="list-style-type: none"> • Staff were clear about their roles and responsibilities. • The practice had nominated leads for key areas, such as the safeguarding of adults and children, infection prevention and control, information governance and records management. Staff were aware of who the leads were. • We found that the systems and processes in managing areas of governance required strengthening. For example, mandatory training, safeguarding registers, medicines management and clinical coding. 	

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance, however this needed strengthening.

	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.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Our review demonstrated that the practice had systems in place for ensuring patients received appropriate care and treatment but some areas needed strengthening such as safeguarding registers clinical coding and medicines management. This included the systems and processes to action and identify patients who needed follow up in a timely way. • Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness and busy periods. • There was a programme of clinical auditing in place to monitor quality and implement improvements. • There were systems in place to review the capacity, demand and workforce to ensure quality and sustainability was regularly assessed and monitored. • There was an emergency and business continuity plan in place. 	

--

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice proactively monitored performance and had a clear understanding of areas for improvement.	

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">Staff told us that when staff consulted with patients remotely their identity was checked.	

- Secure systems were used for patients to share information with the practice.

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice monitored patient feedback through the GP National Patient Survey and the NHS Friends and Family Test (FTT). • The practice had a Patient Participation Group (PPG) which last met in July 2023. At the time of our inspection the practice were trying to increase the number of participants and appoint a new chair. We saw that the meeting was attended by the practice manager, GP, and receptionist. • Staff told us they could provide feedback through meetings and annual appraisals, and felt their views were listened to. • The practice had opted out of the primary care network but had access to services within it. They attended MDT meetings in the locality to discuss complex patients and those requiring further support. For example palliative care and end of life patients, however attendance to those meetings from a clinician was not always consistent. 	

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
Explanation of any answers and additional evidence:	

Examples of continuous learning and improvement

- Meadowbrook Surgery had been awarded the Armed Forces Veteran Friendly accreditation and dementia friend's status.
- The practice actively takes part in research and had achieved an award for patient recruitment onto the research programmes.
- The practice made use of learning events, incidents and complaints to improve the service.

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 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 those aged 25 to 49, and within 5.5 years for those 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.