

# Care Quality Commission

## Inspection Evidence Table

### MARSHALLS CROSS MEDICAL CENTRE(Y02510)

Inspection date: 4, 6 and 12 October 2022

Date of data download: 20 September 2022

## Overall rating: Good

At our previous inspection in August 2018 the practice was rated as requires improvement overall and for safe, effective and well-led. Caring and responsive were rated as good. The Trust had acquired the APMS contract a few months before the inspection and had merged two practices.

At this inspection October 2022 we have rated this practice as Good overall and for safe, effective, caring, responsive and well led.

Please Note: CQC was not able to automatically match data for this location to our own internal records. Data is for the ODS code noted above has been used to populate this Evidence Table. Sources are noted for each data item.

## Safe

## Rating: Good

At our last inspection in August 2018 we rated safe as requires improvement because:

- A robust system for monitoring patients on long term or high-risk medication was not in place and uncollected prescriptions were not dealt with effectively.
- The practice and environment had not been risk assessed in relation to providing care and treatment to patients on a special register.
- Safeguarding processes needed to be strengthened.

At this inspection in October 2022 we rated safe as good because:

- The practice had implemented a system for ensuring that patients on long term or high-risk medication were monitored. Uncollected prescriptions were followed up and monitored.
- Detailed risk assessments for the premises, facilities and to provide services for patients on the specialist allocation scheme had been undertaken and were regularly reviewed.
- Safeguarding processes had been strengthened.

## 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
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
Explanation of any answers and additional evidence: At our last inspection in August 2018 safeguarding processes did not include following up referrals made to health visitors when children missed appointments. At this inspection in October 2022 we found safeguarding processes and registers were monitored and discussed at clinical meetings. Children who were not brought to an appointment were followed up by clinical staff. The practice had access to the trust's safeguarding childrens team for additional guidance or to review any concerns.	

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

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 25 October 2021	Y
There was a fire procedure.	Y
Actions from fire risk assessment were identified and completed. Date of last assessment: 23 September 2022	Partial
Explanation of any answers and additional evidence:	

At our last inspection in August 2018 the provider had not risk assessed the facilities and premises for patients on the special allocation scheme or fixed cords for the window blinds.

At this inspection in October 2022 the provider had completed a risk assessment for the facilities and premises for patients on the special allocation scheme. Blinds had been removed and an opaque covering added to the windows. The actions identified from the fire risk assessment in September 2022 were in the process of being completed at the time of the inspection. For example, evacuation and staff fire training had not been carried out. This was due to be completed by November 2022.

The GP practice is based within a Hospital trust and utilises the trust resources. An annual environment and facilities audit had been undertaken 14 September 2022 to identify areas in the practice that needed attention. We saw that actions were completed on 16 September 2022. Actions included painting walls to remove scuff marks and replace strips on the side of desks that required repair.

## 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. Date of last infection prevention and control audit: 20 October 2021	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

## 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
Explanation of any answers and additional evidence: At the time of the inspection some staff were waiting to attend CPR update training. As part of the practice escalation process for the deteriorating or acutely unwell patient the Trust's emergency team would be called.	

## 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. <sup>1</sup>	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence: Reviews of patient records in relation to the clinical searches identified that care records were managed in line with current guidance.	

## Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) NHS Business Service Authority - NHSBSA)	0.84	0.91	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA)	5.8%	6.1%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules,	4.74	5.73	5.31	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (NHSBSA)	351.2‰	268.9‰	129.2‰	Variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU)(01/07/2021 to 30/06/2022) (NHSBSA)	1.47	1.16	0.59	Variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	9.8‰	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 structured medicines reviews for patients on repeat medicines. <sup>1</sup>	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. <sup>2</sup>	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 <b>NHS England and Improvement</b> Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y

Medicines management	Y/N/Partial
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>As part of this inspection we reviewed a number of set clinical searches. The records of patients prescribed certain high-risk medicines were checked to ensure the required monitoring was taking place. These searches were visible to the practice.</p> <p>Overall, we found that the monitoring of high risk medicines was appropriate with a variety of staff undertaking patient reviews. Following reviews, patients were invited for investigations if necessary.</p> <p>Two of the five patient records had insufficient information recorded in the medication review. Staff were working through a backlog of medication reviews, due to staff absence at the practice and the local primary care network. An audit had been completed to identify which medication reviews were yet to be completed and an action plan was in place to address the shortfalls.</p> <p>The practice had higher prescribing for Pregabalin and Gabapentin and worked in partnership with substance misuse services. The practice had implemented a protocol to improve the monitoring and communication of patients on established maintenance doses which had increased medication compliance and efficacy.</p> <p>The practice had a resuscitation trolley and checks were completed daily and weekly.</p> <p>Emergency medicines were checked by the Trust pharmacy team. The pharmacy team also monitored the temperatures of the fridges using an electronic system. Daily checks were completed by the practice team.</p>	

## 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:	26
Number of events that required action:	24
<p>Explanation of any answers and additional evidence:</p> <p>The practice had an electronic reporting system which staff were confident using. Of the 26 incidents reported between 1 October 2021 and 30 September 2022 all were deemed as low or no harm. Learning from the incidents was discussed at monthly clinical team meetings, fortnightly service development meetings and daily huddles.</p> <p>The provider had a dedicated team to oversee significant events who coordinated investigations and shared learning with the directorates. A weekly incident review meeting took place with managers to disseminate learning to teams. Incidents were also discussed daily at the staff huddles.</p>	

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

Event	Specific action taken
Appointment booking	Staff training needs identified.
Injury to patient	Risk assessment completed and actions taken to prevent a reoccurrence.

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
<p>Explanation of any answers and additional evidence:</p> <p>The provider demonstrated safety alerts had been responded to and patients had been recalled for monitoring.</p>	

## Effective

## Rating: Good

At our last inspection in August 2018 we rated effective as requires improvement because:

- Systems were not in place to monitor NICE and other best practice guidance was followed.
- Key staff had not completed essential training relevant to their role and responsibilities.
- Effective clinical audits had not been completed.

At this inspection in October 2022 we rated effective as good because:

- Systems were in place to monitor NICE and other best practice guidance..
- Staff had completed essential training relevant to their role and responsibility.
- Effective clinical audits had been undertaken and an annual audit programme was in place.

*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.	Y
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.	Y
Explanation of any answers and additional evidence: At our last inspection in August 2018 systems were not in place to monitor that NICE and other best practice guidance was followed.	



At this inspection in October 2022 we found there was an effective system and process for monitoring updates to NICE and other best practice guidance. The provider had a clinical effectiveness and NICE guidance team who supported the practice and mapped compliance. A proforma was completed by the practice when changes or updates were made which was reviewed and monitored by the clinical effectiveness team.

## Effective care for the practice population

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- 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 appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way and a GP took the lead for following the Gold Standard Framework for end of life care. A team of staff visited patients at the end of their life to coordinate care provided.
- 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 experiencing poor mental health were able to book appointments directly with specialist mental health nurses to review ongoing care.
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

- Our clinical record searches found patients with long term conditions were monitored appropriately.
- We found an inconsistent follow up for asthma patients who had two or more courses of rescue steroids. We raised this with the provider who took immediate action and reviewed the patients identified and updated the protocol.

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training, used bespoke assessment templates in the patient record system and had access to specialist nurses for further support and guidance.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	70	73	95.9%	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)(01/04/2020 to 31/03/2021) (NHS England and Improvement)	75	86	87.2%	Below 90% minimum
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)(01/04/2020 to 31/03/2021) (NHS England and Improvement)	74	86	86.0%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR)(01/04/2020 to 31/03/2021) (NHS England and Improvement)	75	86	87.2%	Below 90% minimum

The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England and Improvement)	66	77	85.7%	Below 90% minimum
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Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

#### Any additional evidence or comments

- The practice was below the minimum 90% for four of five childhood immunisation uptake indicators.
- The provider was aware of the lower scores and had a plan to improve uptake.
- The practice contacted parents by phone and letter to invite children for vaccination. This included working with the local health visiting team to follow up missed appointments and discuss concerns.
- Parents could discuss concerns with a GP for advice and guidance.
- The small number of children registered at the practice affected the overall percentages.

Cancer Indicators	Practice	CCG average	England average	England comparison
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).(Snapshot date: 31/03/2022 to 31/03/2022) (UK Health and Security Agency)	72.9%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %)(01/04/2020 to 31/03/2021) (UKHSA)	53.4%	59.3%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2020 to 31/03/2021) (UKHSA)	54.9%	60.4%	66.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2020 to 31/03/2021) (UKHSA)	95.0%	77.5%	90.9%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	52.6%	55.8%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

### Any additional evidence or comments

The provider was aware of the lower achievement in cervical screening and had plans in place to improve screening uptake. This included an audit to identify which patients had not attended so patients could be recalled. Patients were invited by text message or letter to make an appointment with the practice.

### Monitoring care and treatment

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

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

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

Clinical audit was embedded at the practice and used to improve patient care and outcomes. The provider had carried out several audits since April 2022. For example:

- Clinical record audit – the audit identified some templates had not been completed and missing referral information.
- Structured medication review audit – the audit identified the majority of patients medication reviews had been completed but not coded. A plan was put in place to ensure new patients registered with the practice were booked in for a full medication review.
- Heart failure -the audit identified multiple codes were used to diagnose patients. Patient registers were corrected to ensure patients had the appropriate monitoring and recall.
- Diabetes (metformin dosage for patients was reviewed in line with NICE) – the audit identified patients who were not on the recommended dosage.,
- Hydrochlorothiazide – patients were offered skin lesion checks.
- Citalopram – the audit identified 24% of patients prescribed this medicine had not had a medication review within the last 3 months. Medication reviews were scheduled for these patients with particular emphasis on reducing the dose if the patient did not have symptoms.
- Epi-pen audit to alert patients to check the expiry date annually. This audit had identified some patients had paediatric pens and needed adult pens.
- All audits had identified learning and improvements for patient care.
- The practice had an improvement plan to strengthen the management of patients with long-term health conditions and had introduced protocols to support this. For example, introducing an annual recall system for patients with diabetes, chronic obstructive pulmonary disease (COPD), cardio-vascular disease and hypertension to ensure that all the necessary checks were completed in a timely manner.

## Effective staffing

**The practice was able to demonstrate 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
Explanation of any answers and additional evidence:  At our last inspection in August 2018 there was no evidence of formal clinical supervision for medical and clinical staff.  At this inspection in October 2022 we saw the Lead GP session time at the practice had increased and clinical supervision was now in place which included six-monthly reviews for clinical staff and non-clinical staff had check in sessions when needed. Time was set aside for GP's within the working day to discuss cases. All staff had annual appraisals and reviewed performance and training needs.  The provider had started a staffing review to ensure the staff skill mix for patients was appropriate for the number of patients registered at the practice as this had increased.	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	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
Any additional evidence or comments:	
From 1 September 2021 to 31 August 2022, staff referred 502 patients for weight management, with 83% of those referred and completing the programme having lost weight and maintaining that weight loss.	
The practice focused targeted intervention on healthy lifestyle promotion and prevention. From 1 September 2021 to 31 August 2022, 567 patients were recorded as smokers, who were all offered a referral to stop smoking services with 12.8% confirming they have stopped smoking entirely.	

## 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. <sup>1</sup>	Y
Explanation of any answers and additional evidence: Our clinical review of notes where a DNACPR decision had been recorded identified, where possible, the patient's views had been sought and respected. We saw that information had been shared with relevant agencies.	

## Caring

**Rating: Good**

### Kindness, respect and compassion

**Staff treated patients with kindness, respect and compassion. Feedback from patients was mostly 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

Source	Feedback
Patient feedback during the inspection.	We were told there had been changes to appointments but it had been difficult to get a face to face appointment with a GP.

### National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them(01/01/2022 to 30/04/2022) (GPPS)	83.1%	85.1%	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) (GPPS)	76.5%	83.6%	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	94.7%	92.4%	93.1%	No statistical variation



Indicator	Practice	CCG average	England average	England comparison
they saw or spoke to (01/01/2022 to 30/04/2022) (GPPS)				
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) (GPPS)	64.0%	67.9%	72.4%	No statistical variation

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

Any additional evidence
<p>The practice sent a monthly questionnaire to a random selection of patients to obtain feedback. The information was used to inform the practice in shaping service improvements.</p> <p>Leaders had also contacted a local GP practice with higher than average national GP patient survey results with a view to sharing best practice and improving the practice results.</p> <p>The practice participated in the Trust's Patient Experience Council meetings, which included multiple teams such as Healthwatch St Helens and Healthwatch Knowsley. The practice presented at the meeting in September 2022 and provided a full report on the survey along with an action plan. The Patient Experience Council monitored the delivery of the action plan, a summary of which was reported to the Trust Board's Quality Committee.</p>

## 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
<p>Explanation of any answers and additional evidence:</p> <p>During the inspection we observed staff answering the telephone and assisting patients with their needs. For example, a patient's fit note could not be opened using the link provided. A new link was sent to the patient via text message with secure access.</p> <p>The practice had support from advocacy services within the trust and could direct patients externally when required.</p> <p>The practice had a dedicated carers champion, who made regular contact with registered carers</p>	



population via text messaging, offering advice and support and providing patients with contact details for the local Carers Centre. The Carers Champion also ensured that the patient information board was up to date for carers information and support. Positive feedback about this role had been received.

## National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022) <small>(GPPS)</small>	91.4%	90.0%	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: The practice used an external company for interpreters and patient information leaflets could be translated into any language required.	

Carers	Narrative
Percentage and number of carers identified.	There were 306 out of 6149 (as of 27/09/2022) patients registered as carers at the practice. The equates to 5% of the patients registered at the practice.
How the practice supported carers (including young carers).	The practice had a carers champion and had recently planned a coffee morning at the practice for patients who were carers. The practice had contacts with St Helens Carers project and has access to food bank parcels where needed.
How the practice supported recently bereaved patients.	Bereavement information was given to patient families and support for bereavement services was available when needed.

## Privacy and dignity

**The practice respected patients' privacy and dignity.**

	Y/N/Partial
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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: The practice answered all incoming telephone calls away from the reception desk. A room was available for patients who wanted to speak privately with staff.	

## 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: The practice adapted the delivery of services to meet the needs of the patient population. The provider supported this by engaging with patients, community services and stakeholders. The local area was recognised nationally as a deprived area and the provider was working to address access and health inequalities identified. For example, chronic pulmonary disease (COPD) often associated with lifestyle choices and environment, in particular smoking. The practice referred patients within the local primary care network to facilitate and support the diagnosis and treatment of these patients.  The practice aimed to provide five-star person-centered services for their registered population, with a focus on preventative and proactive care.  The provider led the local primary care network and was responsible for recruiting to the additional roles reimbursement scheme for nurse associates, physicians associate, clinical pharmacist, first contact physiotherapist, mental health nurse, a social prescriber and frailty team (advanced nurse practitioner, physical associate and nurse associate). A training hub was developed to support staff induction to these roles which accessed the Trust's training facilities and clinical peer support. Staff were prepared for their roles and enabled patients across the network to access an appropriate clinician for their needs. Staff also could access advice and peer support across the network to enhance care for patients.	

The practice facilities included a separate room which could be used for breast feeding. Both male and female toilets had a baby changing station and sanitary bins.

The provider had extended the practice electronic patient record system to other community services to streamline services and ensure patient information was available for staff. This ensured other health care professionals had access to patient GP records to support and streamline care and treatment.

The practice held the contract for St Helens special allocation scheme to provide care and treatment to patients removed from other GP services. This provided continued access to healthcare services and letters were sent to patients informing them they had been registered on the scheme and how to access services at the practice. Patient risk assessments were completed to identify the best way to meet individual needs.

Staff could refer patients to the social prescribing service to improve their health and wellbeing.

Patients aged 16 and over could book an appointment with a first contact physiotherapist following the chartered society of physiotherapy decision-making guide to book appointments.

A designated GP took the lead for patients residing in care homes and worked alongside the local primary care network frailty team. Weekly ward round GP visits took place and each patient reviewed every 28 days or sooner if required. During these visits, long term health conditions were monitored and reviewed to ensure patients were receiving the appropriate level of care and support and to avoid any unnecessary hospital admissions. Since February 2022 there have been 624 care home visits and 64 visits undertaken for housebound patients across the primary care network.

### Practice Opening Times

Day	Time
Opening times:	
Monday	08:00 – 18:30
Tuesday	08:00 – 18:30
Wednesday	08:00 – 18:30
Thursday	08:00 – 18:30
Friday	08:00 – 18:30
Saturday	Closed
Sunday	Closed

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.

- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travelers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travelers.
- The practice adjusted the delivery of its services to meet the needs of patients with with autism and those who had a learning disability.
- The practice had been awarded a gold status award for the management of patients diagnosed with a learning disability from the commissioners in November 2020.

## Access to the service

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

	Y/N/Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Patients were able to make appointments in a way which met their needs.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
There were systems in place to support patients who face communication barriers to access treatment. (including those who might be digitally excluded).	Y
Patients with urgent needs had their care prioritised.	Y
The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Patients accessed treatment and care by either visiting the practice to make an appointment, calling the practice to arrange a telephone or face to face appointment, by video consultations, online consultations, through the website or through emailing the practice directly.</p> <p>The practice had used flags on patient records to identify patients who may require additional support with appointments. For example, booking appointments when the practice was less busy, longer appointment times, waiting in a quiet area and sending text reminders to notify patients two days before the appointment was due. The practice waiting room displayed information for patients and their families. For example, people who may show signs or have been diagnosed as living with dementia, suicide support, chaperone information and other support available.</p> <p>Following assessment by NHS 111, if indicated, patients could be directly booked into an appointment to see a clinician at this practice and others in the area. Patients who attended the emergency department at the Trust could also be booked into an appointment if their symptoms were appropriate to be reviewed by staff at the practice.</p>	

The practice offered free parking to patients visiting the practice.

## National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone(01/01/2022 to 30/04/2022) (GPPS)	64.4%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment(01/01/2022 to 30/04/2022) (GPPS)	47.9%	47.0%	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) (GPPS)	43.0%	47.7%	55.2%	No statistical variation
( to ) (GPPS)				-

## Any additional evidence or comments

- The practice had taken action to ensure continuity for patients in care homes. Patients were reviewed and seen face to face weekly by the frailty team and at least once every 28 days by a GP.
- Patients on the special allocation scheme could be seen at a time convenient for them.
- A capacity and demand model was in use at the time of the inspection to monitor the number of appointments for the practice population and opportunity to increase if required. This included review of the appointment type and length to make sure patients were reviewed by the most appropriate clinician within a reasonable time frame.

Source	Feedback
NHS Choices	<p>In the last 12 months the practice had received 11 five star, 1 three star and 1 one star ratings from patients.</p> <p>Positive feedback about staff and appointment access. For example, efficient, caring practice and alternative appointments offered.</p> <p>Negative feedback related to a prescription and blood test.</p>

Patient feedback from inspection	Helpful staff Difficulty booking face to face appointments with a GP.
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## 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.	2
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
<p>Explanation of any answers and additional evidence:</p> <p>The practice monitored feedback from patients formally and informally. We were told the practice had received four formal and five informal complaints. The practice had also received seven compliments. NHS website postings were monitored and feedback from the internal survey identified 14 patients were not likely to refer friends and family, but 180 patients were extremely/likely to refer friends and family.</p> <p>We saw complaints followed the NHS complaints standard and acknowledgement letters, investigations were completed and response letters were sent.</p> <p>Complaints and patient feedback were discussed in daily huddle meetings and service development/management and clinical team meetings. Meeting minutes were emailed to staff.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Staff attitude	Staff training need identified.
Care and treatment	The practice had followed national guidance and the complaint was not upheld.

## Well-led

## Rating: Good

At our last inspection in August 2018 we rated well-led as requires improvement because:

- Clinical oversight and governance systems at the service was insufficient and did not demonstrate effectiveness.

At this inspection in October 2022 we rated well-led as good because:

- Clinical oversight and governance systems for the practice had been reviewed and integrated into the Trust's community services directorate.
- The governance arrangements, strategy and plans for the practice were regularly reviewed and monitored.
- There were effective systems and processes for identifying, managing and mitigating risk.

### Leadership capacity and capability

**There was compassionate, inclusive and effective leadership at all levels who could demonstrate that they had the capacity and skills to deliver high quality sustainable care.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
Marshalls Cross Medical Centre is run by St Helens and Knowsley Teaching Hospitals NHS Trust and comes under St Helens Hospital location regulated activities. It is not required to register with the Commission as a separate GP practice location.	
Trust managers and leaders had oversight of the practice and the practice governance systems and processes fed into those of the Trust.	
At this inspection clinical oversight of the practice had been improved as there was now a business manager to support the practice manager and the the Lead GP had dedicated time allocated for clinical oversight of the practice.	
The provider was aware of immediate and future challenges to quality and sustainability. Staffing had been a challenge and the provider had worked hard to maintain a stable workforce. This had been achieved by reviewing the primary care model and utilising a multidisciplinary hybrid approach with telephone appointments, online consultations, face to face appointments and offering other clinician appointments.	

Staff felt supported by leaders and they were visible, approachable and staff enjoyed working at the practice.
The practice was a training practice for medical students and working toward a succession plan which included recruitment of medical trainees once qualified.

## 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
<p>Explanation of any answers and additional evidence:</p> <p>The provider's vision was to provide five star patient care; safety, care, communication, systems and pathways. This was delivered through the strategic aims and values.</p> <p>The provider had an appreciation for the wider care workforce and clear vision to provide high quality sustainable care. This included addressing the health inequalities for the local area. The strategy for the practice included plans to diversify roles and utilise multidisciplinary working. A GP had been employed with a specialism other clinicians could refer to.</p> <p>A staffing review was under way at the time of the inspection as the patient registration list had increased. Staff roles, additional staff, job descriptions and salary structure were included as part of the strategy for providing high quality and sustainable care.</p>	

## Culture

### The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y



The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>All staff we spoke with told us they felt able to raise concerns and areas for improvement with any of the leadership team and they were acted upon and feedback was given. Daily huddle meetings took place for staff to review progress, escalate any concerns and areas for improvement.</p> <p>The practice held daily huddle meetings for all staff to review progress for the day and any ongoing practice issues. Staff health and wellbeing were checked and one to one discussions could take place when needed outside the normal support and appraisal framework. The huddle also included a mindfulness quote and daily or weekly quotes were recorded on the staff notice board.</p> <p>Staff had access to the Trust's Health, Work and Wellbeing Hub that had a range of support available to staff including wellbeing initiatives. The Trust's team briefing included updates of what was available to them.</p>	

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

Source	Feedback
Staff questionnaire	<p>We received positive feedback from the staff questionnaires and were told:</p> <ul style="list-style-type: none"> <li>• There was a supportive management team who were easy to approach (management and clinical) who were receptive and open to change.</li> <li>• There was a great team working environment.</li> <li>• The workload had grown.</li> <li>• Staff were informed of relevant information during daily huddles.</li> <li>• Staff received training and support.</li> </ul>

## Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
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>At our last inspection in March 2018 we found general practice expertise and leadership was not available day to day. Roles and systems of accountability were unclear in relation to the governance of clinical and nursing output.</p>	

The practice governance systems fed into those of the Trust and additional support was available from divisional leaders. Structures, processes and systems of accountability, including the governance and management of the practice complaints and incidents, joint working arrangements and shared services, were clearly set out, understood and effective. Staff were clear about their roles and accountabilities.

At this inspection in October 2022 we found general practice expertise and leadership was now available day to day with support from the lead GP. The provider had recruited experienced GP's and now had a stable medical and clinical team. Structures, processes and systems to support good governance and management were established to promote partnership working and coordinated person-centred care.

There was a comprehensive index of policies, procedures and protocols available to all practice staff to ensure a consistent approach to how the practice operated within the providers community services directorate.

There were daily team meetings for the practice staff and monthly meetings for clinicians to discuss patient care and concerns. These were also discussed at the fortnightly service development management team meetings. Processes for assessing outcomes for patients, such as clinical searches and annual audit programme were managed using technology systems.

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
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> <p>At our last inspection in August 2018 processes for managing risk, issues and performances needed to be strengthened.</p> <p>At this inspection in October 2022 we found an effective process for risk, issues and performance management of systems in place. Risk was recorded on an electronic system and reviewed by the practice and escalated to the community services directorate leads based on the risk score. Risk scores had been reduced with mitigating actions and continued to be monitored to access if actions taken were still appropriate.</p>	

Clinical audit had a positive impact on the quality of care and outcomes for patients. For example the epi-pen audit had highlighted a gap in the transition arrangements for paediatric to adult care for diabetic patients. The audit identified about 15 patients who had paediatric pens and these were replaced with adult pens.

## Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:	
We found strong collaboration, support and a shared focus on improving the quality of care and people's experiences moving between primary and secondary care. Patients registered at the practice who presented in the emergency department who did not require emergency care were redirected to the practice for care and treatment.	
The management team utilised the patient record system to run searches on performance at the practice. The results of these were discussed at the fortnightly service development meetings with the management team, as well as the daily practice meetings and actions identified for improvement.	
We saw the number of documents awaiting processing, referrals to secondary care and new patient records for summarising were monitored daily and discussed in the daily huddles and plans were made for any action required. For example, how work was managed based on the staff rota.	

## 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:  We were told telephone and video consultations took place in a private room with the doors and windows closed to maintain confidentiality.	

### 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:  The provider monitored feedback from a variety of sources and was responsive to the needs of the patients. For example, patients had difficulty in making appointments. Staff training needs were identified and support was given to staff to address this. A staffing review was in progress to ensure patients had access to the appropriate clinician in a timely manner.	

### Feedback from Patient Participation Group.

Feedback
Staff listened to the PPG views and feedback and shared the outcomes of complaints and learning with them. At the time of the inspection the PPG members were few in number and they were trying to recruit new members.
The PPG recognised the patient list size had increased and staff were addressing concerns raised about the number of appointments available for patients.

### Any additional evidence

A coffee morning had been suggested by the PPG which was being planned at the time of inspection to offer support and advice to patients.

## 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: At our last inspection in August 2018 a planned audit programme was not in place.  The Trust employed and trained staff who worked in additional supportive roles across the primary care network. The lead GP coordinated this activity from the practice and benefits were demonstrated of having access to such roles as a frailty team for those patients whose circumstances may make them vulnerable.  At this inspection in October 2022 an annual audit schedule was in place and improvements to the service were made from the findings. For example, two week referral rates had been reviewed focusing on tumor sites. Rejected and inappropriate referrals had been reviewed and identified some referrals had gone to the wrong place and other referrals had not had the preliminary tests required. The referral process now had a triage system in place and were monitored for follow up.  The practice was a member of the Clinical Research Network North West Coast and had recruited 188 patients to 4 NHS research studies up to May 2022 which increased to 229 patients at the time of the inspection. The research study topics included contributed to breakthroughs in diagnosis, treatments, prevention and interventions for patient care for early treatment of COVID-19 in the community with antivirals. Other research studies were being undertaken which included improving primary care's response to domestic abuse and preventing cognitive decline.	

#### 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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

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

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

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

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

#### Glossary of terms used in the data.

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