

# Care Quality Commission

## Inspection Evidence Table

### The Wick Health Centre (1-7310247014)

Inspection date: 18 October to 1 November 2022

## Overall rating: Inspected but not rated

### Safe Rating: Inspected but not rated.

#### Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice had safeguarding children's and adults' policies in place, last reviewed in 2021. However, these required updating because they had the incorrect levels of staff safeguarding training.</li><li>• At the time of the inspection, some of the staff had not completed the appropriate level of children and adults safeguarding training. However, following the inspection, all the non-clinical staff completed the correct level of training.</li><li>• The practice attended monthly multidisciplinary team meetings where safeguarding issues were discussed.</li><li>• The provider explained the processes in place to follow up children who were not brought to appointments or had regular attendance at emergency departments. The staff explained they raised any concerns with the health visitor or safeguarding team.</li><li>• The practice manager explained the practice shared safeguarding concerns with other agencies, using the shared care agreements. In addition, the out of hours services would contact the practice if they were concerned.</li></ul>	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> <li>The provider explained the system for identifying patients who may be at risk on the patient record system.</li> </ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>We reviewed three staff files and found the practice had carried out recruitment in accordance with the regulations.</li> <li>The practice had evidence that staff had maintained their hepatitis B vaccinations, but the practice had not reviewed all the staff immunisations recommended in the UK Health and Security Agency guidance.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: December 2020.	Partial
There was a fire procedure.	Y
Date of fire risk assessment: 26 January 2022 Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice was in a leasehold property and the building maintenance was carried out by the landlords. The practice manager was aware of the risk assessments and checks carried out by the landlord, such as the fire risk assessment and the hardwire electrical check which was carried out in September 2021.</li> <li>The most recent fire drill was June 2022.</li> <li>Ten out of eighteen staff had completed their fire safety training and three had completed their fire warden training. Following the inspection, the practice manager reported there was now only five staff who had not completed their training and two had been on extended leave.</li> <li>The practice had portable electric equipment checked in April 2022 and medical equipment was calibrated in May 2022.</li> <li>At the time of the inspection the health and safety risk assessment had not been reviewed since December 2020.</li> </ul>	

### Infection prevention and control

#### Appropriate standards of cleanliness and hygiene were mostly 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: December 2021	
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice nurse was the lead for the management and prevention of infectious diseases.</li> <li>We observed the practice was clean and tidy, and staff had taken precautions regarding the pandemic. Staff explained the practice was cleaned daily by an independent contractor and staff were aware they had to clean their rooms and equipment prior to use. The staff would inform the manager if there was an issue with the cleaning.</li> <li>The independent company carried out a daily clean and a six monthly deep clean.</li> <li>Nine out of 18 staff had completed their infection prevention and control training. Following the inspection, the practice manager explained 15 staff had completed the training and two were about to commence this following returning from extended leave.</li> </ul>	

### Risks to patients

**Some of the systems to assess, monitor and manage risks to patient safety were not always fully effective.**

	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.	Partial
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.	Partial
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had been affected by staff changes during the pandemic. For example, the practice manager was not in place for two years, two salaried GPs had resigned, and a practice nurse had to remain at home shielding. In addition, throughout the pandemic they had found the recruitment of new staff difficult.</li> <li>At the time of the inspection, the provider explained they had recruited a full time GP in August 2022 and a member of the administration team was promoted to be the practice manager in March 2022. In addition, the practice nurse was able to work from the practice at the end of 2021, and they had employed an additional administrator, a sexual health nurse, and an associate practitioner.</li> <li>Whilst the practice nurse was unable to see patients face-to-face at the practice, the provider had trained the health care assistants to carry out some of the patient checks such as blood pressures checks and employed a phlebotomist. So that all the physical and blood tests could be carried out prior to the practice nurse following them up with a telephone appointment.</li> <li>The provider explained that they used regular locum doctors who were familiar with the practice.</li> <li>At the time of the inspection, three out of seven non-clinical staff had completed their sepsis training. Following the inspection, the practice manager explained all non-clinical staff had completed their sepsis training.</li> </ul>	

- At the time of the inspection, the practice did not have oversight of the completion of basic life support and anaphylactic training. The practice manager had booked an independent trainer prior to the inspection but they had failed to attend the planned session. Following the inspection, the practice manager confirmed that staff were now completing the online training and further face to face training was to be carried out in January 2023.

## 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: <ul style="list-style-type: none"> <li>A review of patient records identified that care records were managed in line with current guidance.</li> <li>The practice had an allocated member of staff to summarise the patients care records; at the time of the inspection the practice had summarised 88% of the patient care records. This is a short summary of the GP medical records. It tells other health and care staff about the patient's medicines and allergies.</li> <li>Patient test results were allocated to the GP whom requested them, and the provider reviewed the patient records global inbox to ensure they were dealt with promptly.</li> <li>The practice had a system in place to monitor urgent patient referrals to ensure the patient attended the appointments.</li> <li>On the day of the inspection, we found the practice patients' blood tests and documents were reviewed and filed promptly.</li> </ul>	

## Appropriate and safe use of medicines

### The practice had systems for the appropriate and safe use of medicines, including medicines optimisation, however the uptake of patient annual medicine reviews had been affected by the pandemic.

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 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)	0.67	0.62	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)	7.3%	9.3%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	4.39	5.76	5.31	Tending towards variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	61.1‰	64.4‰	128.0‰	Tending towards variation (positive)
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)	0.70	0.46	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	9.2‰	5.4‰	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.	Partial
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

Medicines management	Y/N/Partial
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>	Partial
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.	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
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> <li>• We carried out a review of patient records and found patients prescribed high-risk medicines, such as methotrexate, leflunomide, potassium sparing diuretic or azathioprine were put on repeat prescriptions, recalled for tests as required by guidance, and the GP was responsible for checking the necessary tests were carried out prior to prescribing.</li> <li>• The provider explained that due to the difficulties during the pandemic the practice had a backlog of annual medicine reviews to carry out.</li> <li>• We found the systems in place to ensure the annual review of patients' medicines was not fully effective. This was because, when we asked how many patient medicines reviews were overdue and how long they had been overdue, we found the practice was not monitoring this information. In addition, staff were unable to describe the system for the recall of patients for their reviews and described carrying out the reviews opportunistically. Following a discussion with the practice pharmacist they agreed to put in a system in place to monitor and reduce the backlog and the practice manager explained that a pharmacist from the primary care network was now working three days a week at the practice to carry out medicine reviews.</li> <li>• The practice had a system in place to check the emergency medicines had not passed their use by date each month.</li> <li>• The practice had two defibrillators and an oxygen cylinder which was checked monthly. However, on the day of the inspection, one defibrillator had a red cross on the display and the second had out of date defibrillator pads. The practice manager immediately changed the pad and agreed to check the manufacturer guidelines regarding the red cross. Following the inspection, the practice manager confirmed the battery had been replaced and they now checked the defibrators weekly.</li> </ul>	

## Track record on safety and lessons learned and improvements made

### The practice learned and mostly 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.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	3
Number of events that required action:	0
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice had a policy in place for the management of significant events, however this did not have a review date.</li> <li>• The practice manager explained the provider investigated clinically significant events and they investigated the non-clinical events.</li> <li>• A review of the significant events log found it contained brief notes about the outcome of the event, but it did not state the date these were carried out or full details of any learning.</li> <li>• In addition, during the site visit we identified one significant event described below, regarding the emergency equipment, which was not fully acted upon, in regards to the defibrillators.</li> <li>• The practice manager explained any learning was disseminated to staff at practice and clinical meetings.</li> </ul>	

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

Event	Specific action taken
<ul style="list-style-type: none"> <li>• A patient fainted in the practice.</li> </ul>	<ul style="list-style-type: none"> <li>• An ambulance was requested, and the GP attended the patient, with a defibrillator. The incident highlighted that staff had to be sent out multiple times to get equipment, and not all equipment was found in the same place. In response the practice created a pack of essential emergency items to be kept in an identifiable place and this information was shared with clinical and non-clinical admin staff at the practice meetings.</li> </ul>
<ul style="list-style-type: none"> <li>• Documents were sent to the wrong patient.</li> </ul>	<ul style="list-style-type: none"> <li>• The practice recognised there had been a breach of data protection. In response the practice identified an area of learning and training needs and the processes required reviewing.</li> </ul>

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. <sup>1</sup>	Partial
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	

- The practice had a safety alert policy in place to instruct staff and ensure they were followed up. However, on the day of the inspection a review of a safety alert which instructed staff to inform patients of the possible risks of a medicine for diabetes, had not been followed up for 53 patients. At the inspection the provider agreed to immediately inform the patients of the risk. Following the inspection, the practice manager confirmed that patients had been contacted and followed up.
- At the time of the inspection the practice did not have a fully effective system in place to record and act on safety alerts. The practice pharmacist agreed to review and clarify the process with the practice manager. Following the inspection, the practice manager explained that the practice pharmacist was now clearly responsible for the receipt management and action of safety alerts and they had commenced a spreadsheet to enable them to ensure they could evidence the action the practice had taken in response to an alert.



## Effective

## Rating: Inspected but not rated.

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 were mostly delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools. However, the practice's uptake of patient's long-term health conditions and annual health reviews had been affected by insufficient staff.**

	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. <sup>1</sup>	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. <sup>2</sup>	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. <sup>3</sup>	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 prioritised care for their most clinically vulnerable patients.	Y

### Effective care for the practice population

#### Findings

- The provider explained that the loss of staff had affected their uptake of annual health reviews, such as for people with a mental illness and for people with a learning disability.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. The practice provided unverified data which demonstrated from 1 April 2021 to 31 March 2022 the practice had completed 91 out of 137 reviews.
- All patients with a learning disability were offered an annual health check. The provider submitted unverified data that demonstrated from the 1 April 2021 to 31 March 2022 the practice had completed 25 out of 39 annual reviews.

- The practice had a duty doctor available each day who triaged all patients who contacted the practice for an appointment.
- The practice had a range of different practitioners with different skills and competencies, but it did not have a protocol in place for staff to refer to ensure the appropriate allocation of appointments.
- 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.
- The practice had a list of housebound patients and ensured they received a home visit four times a year to review their care and treatment.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice demonstrated that they had a system to identify people who misused substances.
- Patients with poor mental health, including dementia, were referred to appropriate services. Such as the psychiatric liaison clinic.
- The practice attended monthly agency multi-disciplinary team meetings. Where patients who experienced mental health, issues were discussed.
- The practice had access to a doorstep assessment and oximetry service where clinical staff visited patients who were unable to leave their homes to carry out physical observations.

## Management of people with long term conditions

### Findings

- The clinical searches of patient records identified the practice had 390 patients on the asthma register and 20 had been prescribed two or more courses of rescue steroids. We reviewed a sample of five patients' records and found there was inconsistent follow up and two patients had not had an asthma review. Also, a review of a sample of seven patients with diabetic retinopathy who had a high blood glucose found two patients with an overdue diabetes and medication reviews.
- The provider explained the practice nurse normally carried out the diabetes and asthma patient reviews, however during the pandemic they were unable to see patients face-to-face. In addition, the practice had lost two salaried GPs, and this had affected their uptake of patient long-term health condition reviews.
- The practice provided unverified data regarding the number of patient long-term health conditions reviews from April 2021 to 31 March 2022: -
  - The practice had completed 136 out of 490 asthma reviews.
  - The practice had completed 312 out of 513 diabetic reviews.
  - The practice had completed seven out of 78 chronic obstructive airways disease (COPD) reviews.
- In response to the limited uptake of patient long-term health condition reviews, the provider explained the practice nurse had returned in May 2022 and they had trained the health care assistants to carry out part of the reviews, such as blood pressures. They had also employed a phlebotomist and an associate practitioner, and a salaried GPs had joined the clinical team in early 2022, which they hoped would increase their performance.
- In addition, following the inspection, the practice had commenced patient long-term health conditions three days a week, and prioritised patients' appointments according to their risks. They were also employing locum staff to ensure the facilitation of the clinics.
- To demonstrate the improvements made the practice provided unverified data from the 1 April 2022 to the date of the inspection.

- The practice had completed 130 out of 480 asthma reviews.
- The practice had completed 244 out of 514 diabetic reviews.
- The practice had completed 39 out of 79 chronic obstructive airways disease (COPD) reviews.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- The practice was involved in a 12-month trial that offered patients with suspected hypertension ambulatory blood pressure monitoring.
- Where appropriate patients with COPD were offered rescue packs.
- The practice had access to chronic disease clinics for patients with long-term health conditions.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	62	82	75.6%	Below 80% uptake
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)	56	67	83.6%	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)	56	67	83.6%	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)	55	67	82.1%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	46	79	58.2%	Below 80% uptake

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 provider explained the uptake of childhood immunisations had been affected by the practice nurse inability to see patients face-to-face during the pandemic and the difficulty in recruiting staff.
- In response the practice had a dedicated member of staff who ensured the recall of those who had not attended during the pandemic.
- The practice provided unverified data to demonstrate from the 1 April to 2022 to the date of the inspection, the practice had completed: -
  - 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) was 52 (65%).
  - The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) was 58 (77%).
  - The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) was 37 (54%).
- The staff explained all patients who were not brought into appointments were telephoned by the practice and if undecided offered a GP consultation. In addition, they were identified on the patient record system and the health visitors were informed if the practice had concerns.

Cancer Indicators	Practice	SICBL 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) (UK Health and Security Agency)	71.4%	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)	52.8%	54.8%	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)	51.9%	58.1%	66.8%	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)	75.0%	53.3%	55.4%	No statistical variation

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.

## Any additional evidence or comments

- Due to the pandemic the practice did not carry out cervical screening from 16 March to 3 June 2020.

- The practice had employed a specialist sexual health nurse to help with the cervical screening backlog.
- The practice provided unverified data to demonstrate from the 1 April to the time of the inspection the practice had an uptake of:
  - Patients aged 25 to 49 was 75%.
  - Patients aged 50 to 64 was 82%.

## Monitoring care and treatment

**The practice monitoring the outcomes of care and treatment had been affected by staffing difficulties.**

	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.	Partial
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

Any additional evidence or comments
<ul style="list-style-type: none"> <li>• Although staff had taken part in national and local quality improvement initiatives. Due to the staffing difficulties the practice had not carried out any direct audits but had been involved in some audits with the primary care network pharmacist and the primary care mental health team.</li> <li>• A pharmacist had carried out an audit of the monitoring of Direct-acting Oral Anticoagulants (DOACs) in November 2022.</li> <li>• The primary care mental health team had carried out an audit of antidepressants prescribing in under patients 25 years in January 2022.</li> <li>• At the time of the inspection the practice was carrying out a quality improvement project on access and availability, which had resulted in the use of patient triage to increase availability.</li> </ul>

## Effective staffing

**The practice was not always 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.	Partial
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y

The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The provider explained a practice manager had not been onsite for two years, and in March 2022 a new practice manager was recruited. Due to the lack of a practice manager onsite the practice had found staff training had not always been completed.</li> <li>At the time of the inspection, although we found the practice manager had started to ensure they had full oversight of staff training, this was not yet full completed. For example, some staff had not completed their mandatory training such as infection control, information governance, fire, and health and safety.</li> <li>The practice had recently employed a physician associate and a pharmacist who within their competencies carried out patient consultations. The provider explained they allocated time to review all their patient consultations and discussed any issues at the end of each session, however this was not formally recorded.</li> <li>At the time of the inspection, the physician associate and a pharmacist did not have a scope of practice in place. This provided the range of roles, functions, responsibilities and activities which they were educated, competent and had authority to perform.</li> </ul>	

### 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice attended monthly multi-disciplinary team meetings with other agencies and had contact with the psychiatric liaison team and the neighbourhood clinical teams to discuss complex patients' treatment, care and welfare.</li> </ul>	

### Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y

Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had access to a wellbeing practitioner, a wellbeing coach, an anti-violence support worker and social prescribers who provided support and advice.</li> </ul>	

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. <sup>1</sup>	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice did not have a record of whether staff had completed their Mental Capacity Act training.</li> </ul>	

## Caring

**Rating: Inspected but not rated**

### Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The GP NHS survey results demonstrated that patients were treated with respect and compassion.</li> </ul>	

- During the site visit we observed staff displaying a non-judgmental attitude towards patients.
- Non-clinical staff had completed customer care training.

## 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 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)	93.6%		78.8%	84.7%	Tending towards variation (positive)
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)	97.0%		76.4%	83.5%	Variation (positive)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	99.5%		89.2%	93.1%	Variation (positive)
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)	83.9%		65.7%	72.4%	No statistical variation

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

## Any additional evidence

- The practice told us for patient feedback they monitored the website care concern, however we found this had only four responses in the last 12 months.

## 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:	

## 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 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)	94.8%	84.6%	89.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice was ensuring information was available about the practice to match the practice population such as Cantonese, Spanish and Turkish.</li> </ul>	

Carers	Narrative
<ul style="list-style-type: none"> <li>Percentage and number of carers identified.</li> </ul>	<ul style="list-style-type: none"> <li>The practice had identified 149 carers at the practice. out of a population of approximately 7,700. (Approximately (2%) of the practice population group.</li> </ul>
<ul style="list-style-type: none"> <li>How the practice supported carers (including young carers).</li> </ul>	<ul style="list-style-type: none"> <li>The practice had a system to identify carers on the patient record system which enable staff to offer longer appointments.</li> <li>The practice had Information on the practice website about carers association which held events locally.</li> </ul>

	<ul style="list-style-type: none"> <li>The practice had a wellbeing coach and practitioners available to provide support.</li> </ul>
<ul style="list-style-type: none"> <li>How the practice supported recently bereaved patients.</li> </ul>	<ul style="list-style-type: none"> <li>The practice would make contact with the bereaved and offer an appointment if appropriate.</li> </ul>

## 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:	

## Responsive

## Rating: Inspected but not rated.

### 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"> <li>The practice manager explained that the practice had a duty GP each day from 8am, with a minimum of two other GPs, working during opening hours. The number of GPs working on a Thursday was four.</li> <li>The practice was available from 9am to 4.30pm from Monday to Thursday.</li> <li>A sexual health nurse was available from 9am to 6.30pm on a Tuesday.</li> <li>The practice had commenced its own phlebotomy service which was available Monday, Tuesday and Thursday from 8.30am to 2.30pm.</li> <li>The practice manager explained that every patient who required an appointment would be triaged by the duty doctor and patients would have a choice of a face-to-face or telephone appointment.</li> <li>The practice had a telephone system that enabled patients to be called back when they became the next to be answered by the receptionist.</li> </ul>	

- Patients had out of hours access to GP hubs for appointments in the evening and weekends.
- The practice manager submitted unverified data that demonstrated for the month of October the practice had carried out 821 telephone and 473 face to face GP appointments.

### Practice Opening Times

Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
	Telephone lines were open from 8am to 6pm.
Appointments available:	
Monday	9am to 6:30 pm
Tuesday	9am to 6:30 pm
Wednesday	9am to 6:30 pm
Thursday	9am to 6:30 pm
Friday	9am to 6:30 pm
Practice nurse appointments	
Monday to Thursday	9am to 4.30pm

### 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, and the practice tried to allocate families the same GP.
- 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 had a proactive register of housebound patients and ensured they received a home visit four times a year to review their care and treatment.
- The practice had a proactive register for patients who attended the hospital multiple times and provided them with a consultation with a nurse and GP and extended appointments.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- There was a medicines delivery service for housebound patients.
- 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. For example, 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 travellers. The practice manager explained that patients with no fixed abode would be seen by the GP immediately.

## Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>All patients were triaged by a duty doctor and offered an appointment of their choice.</li> </ul>	

## National GP Patient Survey results

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

Indicator	Practice	SICBL average	England 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)	61.6%	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)	68.9%	50.6%	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)	64.6%	52.6%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	85.9%	65.1%	71.9%	Tending towards variation (positive)

Source	Feedback
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For example, NHS Choices	
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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.	8
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had a complaints policy in place that was last reviewed in December 2021.</li> <li>The practice manager explained they tried to respond to complaints within 28 days.</li> <li>The practice manager responded to complaints with the assistance of the provider if the complaints were regarding clinical care.</li> <li>The practice submitted a list of complaints in 2022. This had brief comments and did not clearly evidence the lessons learnt by the practice. In addition, the clinical meetings and reception meeting minutes did not have complaints as an agenda item.</li> </ul>	

Example(s) of learning from complaints.

Complaint	Specific action taken
<ul style="list-style-type: none"> <li>Regarding the appointment process</li> </ul>	<ul style="list-style-type: none"> <li>The staff had a general discussion regarding telephone appointment being at the patients at their preferred times.</li> </ul>
<ul style="list-style-type: none"> <li>Regarding repeat prescriptions</li> </ul>	<ul style="list-style-type: none"> <li>The practice changed the process following the complaint to ensure further mistakes were not made.</li> </ul>

## Well-led

## Rating: Inspected but not rated

### 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"> <li>The provider explained the practice's challenges during and following the pandemic was the change of staff and being unable to recruit. However, they had recently recruited the staff and had now were implementing plans for improvement.</li> <li>The provider explained how they recognised that the practice manager required support in the role due to the previous manager not being onsite.</li> </ul>	

## Vision and strategy

### The practice had a vision and strategy to provide 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"> <li>The staff described the practice as a family practice, where staff knew patients well and would go above and beyond to provide support for patients. The practice charter stated that staff were there to provide a high level of care and support to patients, and always treat them with dignity and respect</li> </ul>	

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	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
Explanation of any answers and additional evidence:	

## Governance arrangements

**The practice had systems to support good governance and management but these required review and improvements.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice manager was recruited in March 2022 and the previous practice manager had not been onsite for over two years and had not provided a detailed handover. The practice manager explained how they had been working through all the systems and process to review and update them but had not completed this at the time of our inspection. The areas we found that required further improvements were: - <ul style="list-style-type: none"> <li>➤ Oversight of staff training.</li> <li>➤ Review of policies and procedure to ensure they were accessible and reflected current processes.</li> <li>➤ Ensuring complaints and significant events were discussed regularly in reception and clinical meetings.</li> <li>➤ A clear systems and process was required for the recall of patients for annual medicines reviews.</li> <li>➤ The system and process for safety alerts was unclear and required further improvements.</li> <li>➤ A scope of practice for clinical staff was required to ensure they worked within their competencies.</li> </ul> </li> </ul>	

## Managing risks, issues and performance

**There were some ineffective processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Partial
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Partial

When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
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Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>At the time of the inspection the practice was carrying out a quality improvement project on access and availability, which had resulted in the use of patient triage to increase availability to appointments.</li> <li>The practice was also working with the primary care network to deliver quality measures.</li> <li>The practice had not reviewed their health and safety risk assessment annually.</li> <li>The provider had recognised that due to the pandemic the practice had a poorer uptake of long-term health condition and medicine reviews and in response the provider had recruited new staff.</li> <li>However, in regard to the medicine reviews we found at the time of the inspection they had not monitored the amount of the backlog and did not have a plan for improvements in place.</li> <li>Some staff had not completed their sepsis or basic life support training. Following the inspection, the practice manager explained all non-clinical staff had completed their sepsis training. In addition, they confirmed that staff were now completing the online basic life support training and further face to face training was to be carried out in January 2023.</li> </ul>	

### Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice manager explained that governance meetings were held regularly with the provider to review performance, but these were not always recorded.</li> <li>The practice had had not informed CQC of a change to their partnership status following the retirement of one of the partners.</li> </ul>	

### 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Staff had been supported to work at home during the pandemic.</li> <li>• Patients who used E consult to ask for an appointment or advice were responded to within 48 hours.</li> </ul>	

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

**The practice sometimes 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.	Partial
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• At the time of the inspection the practice did not carry out their own patient survey but reviewed the GP survey.</li> <li>• Staff told us that leaders would listen to their concerns and feedback.</li> <li>• The practice manager explained the staff held weekly clinical meetings, and monthly reception and practice meetings.</li> <li>• The provider submitted a copy of three clinical and reception meeting minutes. These were brief and did not use set agendas to ensure staff were fully informed of complaints and significant events at the practice.</li> <li>• The practice had a patient participation group meeting in July 2022.</li> </ul>	

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> <li>• We spoke with a member of the PPG who provided positive feedback about the service and described how the staff would listen and act on patient feedback.</li> </ul>

### Continuous improvement and innovation

**There were 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:	
<ul style="list-style-type: none"> <li>The practice was working towards becoming a training practice.</li> <li>The practice was working with the primary care network to make improvements.</li> </ul>	

#### Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practice's 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 SICBL 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 SICBL 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.