

Care Quality Commission

Inspection Evidence Table

The Village Surgery (1-576412747)

Inspection date: 25 and 27 October 2022

Date of data download: 18 October 2022

Overall rating: Requires improvement

At our previous inspection on 4 April 2022, we rated the practice as inadequate overall because effective governance systems were not in place to ensure safe and effective services were provided. At this inspection we rated the practice as requires improvement overall because there had been significant improvements in the key questions safe, effective and well-led. However, a small number of issues had not been fully addressed.

Safe

Rating: Requires improvement

At our previous inspection in April 2022, we rated the practice as inadequate for providing safe care and treatment. This was because:

- Recruitment checks were not fully carried out in accordance with regulations.
- A formal system for monitoring that professional registrations were in date was not in place.
- Systems to verify and demonstrate the safe recruitment of staff, employed by the primary care network (PCN) and working within the practice, were not in place.
- Recruitment files were disorganised making it difficult to clearly assess what recruitment checks had been completed.
- There was evidence to demonstrate that some staff vaccinations were maintained in line with national guidance however there continued to be gaps in other staff records.
- It was unclear if the recommendations in the legionella and fire risk assessments and building surveys had been actioned.
- Test results were not always reviewed in a timely manner.
- Non-clinical prescribers had not been provided with clinical supervision.
- Some patients on high-risk medicines were not monitored appropriately.
- Medicines and Healthcare products Regulatory Agency (MHRA) alerts had not always been fully actioned.
- Themes and trends relating to significant events were not identified to drive improvement.

At this inspection we rated the practice as requires improvement. This was because there had been significant improvements. In particular:

- Monitoring to ensure professional registrations were in date was in place.
- Systems to verify PCN staff working within the practice were appropriately recruited and supported were in place.
- Recruitment files were organised.
- There was a system in place for monitoring staff immunisation and, risk assessments had been completed for non-clinical staff where required.
- Action plans had been put in place to mitigate issues identified in risk assessments, for example fire prevention.
- Test results were reviewed in a timely manner.
- Systems to monitor the prescribing and consultations of non-medical prescribers had been implemented.
- Patients on high risk medicines were monitored appropriately.
- Themes and trends related to significant events had been identified although this was not formally documented.

However, we found a small number of ongoing issues:

- A clinical member of staff had not completed training in safeguarding children and infection prevention.
- Recruitment checks were not fully carried out in accordance with regulations for some staff whose files we reviewed.
- A risk assessment was not in place for a clinical member of staff whose immunity status to hepatitis B was unknown.
- MHRA and Central Alerting System (CAS) alerts were not always followed.
- Patient Specific Directions (PSD) were not always authorised by a prescriber before a medicine was administered.
- Systems to manage the prescribing of a high number of short acting asthma inhalers were not effective.

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.	Yes
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
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.	Yes
<ul style="list-style-type: none"> We found there were systems in place to discuss and review the care of children and vulnerable adults within a multidisciplinary team. Most staff had completed safeguarding training at levels appropriate to their role. We found that a clinical member of staff had not completed recent training in safeguarding children. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial
<p>At our previous inspection in April 2022 we found that:</p> <ul style="list-style-type: none"> A formal system for monitoring that professional registrations were in date was not in place. Systems to verify and demonstrate the safe recruitment of staff, employed by the primary care network (PCN) and working within the practice, were not in place. Recruitment files were disorganised making it difficult to clearly assess what checks had been completed. There was no record of staff immunisations in the records of some members of staff. <p>At this inspection we found that:</p> <ul style="list-style-type: none"> A formal system for monitoring that professional registrations were in date had been put in place. This needed to be embedded into every day practice to ensure annual checks were completed. We found that systems to verify and demonstrate the safe recruitment of staff, employed by the PCN and working within the practice, were in place. Recruitment files were clearly organised and included a summary of where to locate various documents within each staff file. 	

- A system had been put in place to record and monitor the immunisation history of each member of staff. Where non-clinical staff had not acquired immunity to hepatitis B, a risk assessment had been completed to mitigate potential risks to patients and staff.

However we reviewed the records of 5 members of staff and found that:

- A health assessment had not been completed for 2 members of staff and an explanation of gaps in employment history had not been documented for 2 members of staff.
- There was no record of immunity to hepatitis B, or a risk assessment to mitigate potential risks, for a clinical member of staff.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. The Village Surgery date of last assessment: 3 March 2022 Pinxton Surgery date of last assessment: 24 February 2022	Yes
There was a fire procedure.	Yes
The Village Surgery date of fire risk assessment: 16 October 2020 Pinxton Surgery date of fire risk assessment: 2 July 2014 however monthly assessments had been carried out by the practice manager.	Yes
Actions from fire risk assessment were identified and completed.	Partial
<p>At our previous inspection in April 2022 we found that:</p> <ul style="list-style-type: none"> • It was unclear if the recommendations in the legionella risk assessment for the branch practice had been actioned. • An action plan to address and monitor the required improvements identified in the fire risk assessment had not been completed. • Issues identified in the 2 building surveys had not been addressed. <p>At this inspection we found that:</p> <ul style="list-style-type: none"> • A legionella risk assessment had been completed on 26 and 27 September 2022 at the branch practice in Pinxton. The provider was waiting to receive the report and informed us an action plan would be put in place and monitored if any issues were identified. • An action plan to address and monitor the required improvements identified in the fire risk assessment for the branch practice in Pinxton had been put in place. We found that there were 3 outstanding actions waiting to be completed. The provider informed us they would update the action plan when the required work was completed. • Action plans with completion dates had been completed to address the issues identified within the building surveys. • Other health and safety checks had been completed. For example, portable appliance testing, calibration of equipment and gas and electrical safety checks. 	

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 (IPC).	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: The Village Surgery: August 2022 Pinxton Surgery: 24 August 2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<ul style="list-style-type: none"> We reviewed the training records of 5 members of staff and found that most staff had completed training in IPC. However, a clinical member of staff had not. 	

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.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
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.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes
<ul style="list-style-type: none"> The provider was aware of the challenges in managing staff absences. Where staff had left or were planning to leave the provider had employed temporary staff to cover the gaps until new staff members were recruited. Additional receptionists and a salaried GP had been recruited to improve access to appointments. 	

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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes

Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
<p>At our previous inspection in April 2022 we found that:</p> <ul style="list-style-type: none"> Sixty-two test results were waiting to be processed. <p>At this inspection we found that:</p> <ul style="list-style-type: none"> There was a small number of outstanding blood tests waiting to be reviewed and none of these results were more than 2 days old. Our 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

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)	1.07	0.79	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)	7.7%	8.0%	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)	5.08	5.09	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	183.9‰	151.3‰	128.0‰	No statistical variation
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)	0.17	0.51	0.59	Variation (positive)

Indicator	Practice	SICBL average	England average	England comparison
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	7.8‰	7.4‰	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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
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.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
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.	Not applicable
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
At our previous inspection in April 2022 we found that: <ul style="list-style-type: none"> The provider had updated their systems for the secure storage of prescription stationery. 	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> One hundred and fifty-five out of 1,303 patients prescribed a medicine for the treatment of high blood pressure had potentially not received the required monitoring. A system to monitor the prescribing and consultations of non-medical prescribers was being developed however it had not been fully implemented. <p>At this inspection we found that:</p> <ul style="list-style-type: none"> From our clinical searches we identified that 39 out of 1,291 patients prescribed a medicine used in the treatment of high blood pressure had not received the required monitoring. This was a significant improvement since our previous inspection. We reviewed 5 of the 39 clinical records and found that the practice had recalled all of these patients for monitoring. Where patients continued to be non-compliant with monitoring, the provider changed their monthly repeat prescriptions to weekly. A system to monitor the prescribing and consultations of non-medical prescribers had been implemented. We reviewed the clinical supervision notes of 2 members of staff and found there was a clear audit trail, review and, suggestions for improvements had been made. We spoke with a non-medical prescriber who was extremely positive about the mentorship and supervision they had received. <p>However:</p> <ul style="list-style-type: none"> The system implemented at the previous inspection for the secure storage and tracking of prescription stationery throughout the practice was ineffective. Records of prescription stationery did not tally with actual prescription stationery held within the practice. Immediately following our inspection, the provider forwarded to us an action plan of the changes they have made to the system and the monitoring checks that would be completed to ensure staff compliance with the changes. We found that some Patient Specific Directions (PSD) had not been appropriately authorised by a prescriber before the medicine had been administered. Our clinical searches identified 72 patients out of 832 that had been prescribed 12 or more short acting asthma inhalers over the last 12 months. We reviewed 5 of the 72 patient records and found that 2 patients had not received a recent asthma review. We found that a patient had received 28 inhalers within the last 12 months. We found that they had received a recent asthma and medication review however, the reviews had failed to identify the high usage of short acting asthma inhalers. 	

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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes

There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	6
Number of events that required action:	6
<p>At our previous inspection in April 2022 we found that:</p> <ul style="list-style-type: none"> There was a significant events policy in place however, it did not include the need to review significant events over time to identify trends or, to review the effectiveness of any changes made. <p>At this inspection we found that:</p> <ul style="list-style-type: none"> The significant events policy had been updated to identify trends over time. Through conversation with the provider they clearly described the trends they had identified, for example a delay in referrals to secondary care, and the action they had taken to address the issue. A formal process of recording this though was not in place. Significant events were reviewed at dedicated significant event meetings and any learning from the event was shared with appropriate staff. 	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
A patient's medicine had been changed by secondary care and the practice informed of the required changes. However, the required changes had not been made because the letter was not forwarded to a clinician to action.	Staff were reminded that hospital letters with medication changes must be sent to a clinician.
There was a delay in referring a patient for a 2-week wait referral because an incorrect form was completed.	Clinicians were advised to complete the form with the patient to ensure appropriate information was included. Clinicians were reminded where to locate the correct forms and laminated notices with the appropriate referral codes were available in clinical rooms. The induction pack for locum GPs had been updated to include the process of making a 2-week wait referral to secondary care.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial
<p>At our previous inspection in April 2022 we found that:</p> <ul style="list-style-type: none"> • It was not always clear, in line with a Medicines and Healthcare products Regulatory Agency (MHRA) safety alert, that appropriate contraceptive advice and long-acting reversible contraceptives had been offered to female patients of childbearing age who were prescribed a medicine that had the potential to cause congenital malformations. <p>At this inspection we found that the provider was unable to demonstrate that the care of women of childbearing age, prescribed medicines with the potential to cause congenital malformations during pregnancy, had received the advice, care and treatment in line with MHRA alerts. We found that:</p> <ul style="list-style-type: none"> • Pregnancy prevention plans were not always in place or reviewed annually. • Annual risk acknowledgement forms were not recorded in patients' records and there was a lack of evidence that they were checked by clinicians before repeat prescriptions were issued. • A discussion of the risks of these medicines was not always recorded in patient records. • Advise on contraceptive advice and long-acting reversible contraceptives was not always recorded in patient records. <p>Following our inspection the provider forwarded to us an audit of the patients prescribed these medicines that they had referred to secondary care. However, the audit did not address all of the issues identified during our inspection.</p> <p>The provider was unable to demonstrate that paediatric pulse oximetry was available at the main practice in line with a central alerting system (CAS) alert issued in December 2018.</p>	

Effective

Rating: Good

At our previous inspection in April 2022, we rated the practice as requires improvement for providing safe care and treatment. This was because:

- We continued to identify patients with a potentially missed diagnosis of diabetes or chronic kidney disease (CKD).
- Patients with diabetes, CKD or hypothyroidism had not always received the required monitoring.
- Systems to address poor staff performance were not fully effective.
- Cervical screening rates were below the national target.

At this inspection we rated the practice as good for providing an effective service. This was because:

- There had been significant improvements in the monitoring of patients with potential diabetes or CKD.
- Patients with diabetes, CKD or hypothyroidism had either received the appropriate monitoring or been invited to receive the appropriate monitoring.
- Systems to address poor staff performance had been put in place.
- Whilst cervical screening rates remained slightly below the national target, the provider was able to describe the action they had taken to try and address it.

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

Effective care for the practice population

Findings

- The practice provided weekly ward rounds for patients living in care homes where the practice provided care and treatment.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients.
- 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.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

At our previous inspection in April 2022 we found that:

- There were 17 patients with a potentially missed diagnosis of diabetes and 71 patients with a potentially missed diagnosis of chronic kidney disease (CKD).
- Patients with diabetes, CKD or hypothyroidism had not always received the required monitoring.

At this inspection we found that:

- There had been a significant reduction in the number of patients with a potentially missed diagnosis of diabetes or CKD. We reviewed 5 patient records and found that 4 of the patients did not have a long-term condition, however appropriate monitoring remained in place, and the other patient had a diagnosis of diabetes.
- Patients with diabetes and CKD had received the required monitoring. We found that 9 out of 366 patients with hypothyroidism had not received the appropriate blood test monitoring however, there was evidence the practice had recalled the patients for the tests to be completed.
- 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.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- 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 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)	103	105	98.1%	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)	95	103	92.2%	Met 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)	95	103	92.2%	Met 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)	95	103	92.2%	Met 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)	110	119	92.4%	Met 90% minimum

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

Any additional evidence or comments

- The practice had met the minimum 90% target for all 5 childhood immunisation uptake indicators.

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)	74.7%	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)	62.2%	62.3%	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)	67.6%	70.4%	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)	47.8%	53.0%	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
<ul style="list-style-type: none"> At our previous inspection in April 2022, we found that the practice's cervical screening rate was below the national target of 80%. At this inspection we found that the cervical screening rate was comparable with our findings at the previous inspection and remained below the 80% target. Staff we spoke with told us that there was a system in place for recalling women who did not attend for their screening. They told us that women were informed of the benefits of receiving the screening however, some women refused to attend.

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.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

Examples of improvements demonstrated because of clinical audits or other improvement activity in past 2 years

<p>The practice had carried out audits based on new evidence and updates to improve the quality of the care they provided. In particular, an audit:</p> <ul style="list-style-type: none"> To assess the compliance with the recommended vaccination schedule in patients that had received a splenectomy. To monitor anticoagulation in patients with prosthetic heart valves.

Any additional evidence or comments
<ul style="list-style-type: none"> The provider met monthly with the CQC and the Integrated Care Board (ICB) to monitor progress against their action plan to drive improvements within the practice.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
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.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>At our previous inspection in April 2022 we found that:</p> <ul style="list-style-type: none"> Salaried GPs had not received an appraisal with the provider. There was an inconsistent approach to the frequency of auditing non-medical consultations amongst GP partners. There were areas where the provider had been made aware of poor staff conduct and no action or support had been put in place. <p>At this inspection we found that:</p> <ul style="list-style-type: none"> Salaried GPs had received an annual appraisal with the provider. A system for auditing non-medical consultations was in place. A member of staff we spoke with was extremely positive about the supervision and mentorship they had received. We saw records of meetings that had been held to address poor staff conduct. 	

- Most staff had completed training required by the provider, however a clinical member of staff had not completed training in safeguarding children, fire prevention, equality and diversity, information governance or infection prevention.
- Staff had not completed training to support autistic people and people with a learning disability which is a legal requirement under the Health and Care Act 2022. Immediately following our inspection the provider informed us this had been added to their list of mandatory training for staff.

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.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
<ul style="list-style-type: none"> • The practice used special notes to share important patient information with out of hours services. 	

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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes

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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
<ul style="list-style-type: none">From our review of patients' records where a DNACPR decision had been recorded, we found where possible patients' views had been sought and respected. We found 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 mixed about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

Patient feedback	
Source	Feedback
NHS website	There was a positive comment regarding a vast improvement in the service offered to patients.
Patient compliments received by the practice.	The practice had received 13 compliments from patients and reviewed what patients told them they did well. In particular, patients said that staff were efficient, helpful, kind, caring and understanding.

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)	69.2%		84.3%	84.7%	Variation (negative)
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)	73.0%		83.8%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	83.6%		93.4%	93.1%	Tending towards variation (negative)
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)	51.0%		72.5%	72.4%	Tending towards variation (negative)

Any additional evidence or comments

All 4 caring indicators from the National GP Survey were below the local and national averages. The provider informed us that they were aware of this and had discussed the reasons why. Minutes of meetings we reviewed supported this. In response to patient concerns, staff had been provided with customer service training and where individual staff issues were identified, processes to manage their behaviour had been put in place. During the course of our inspection we observed staff being caring and compassionate towards patients.

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	No

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.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
<ul style="list-style-type: none"> • Easy read leaflets were available for people with a learning disability. • The care co-ordinator and social prescriber supported patients and their carers to access community services. 	

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)	78.5%	90.2%	89.9%	Tending towards variation (negative)

Any additional evidence or comments

- The practice had identified the potential reasons for a fall in patient satisfaction with involvement in decisions about their care and treatment. In response to this staff had been provided with customer service training and locum GP induction packs had been updated.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes
<ul style="list-style-type: none"> • There was a carer's board in the waiting rooms that signposted carers to support and advice. • Information leaflets to support groups were available within the practice. For example, support for veterans, high alcohol consumption. 	

Carers	Narrative
Percentage and number of carers identified.	The number of carers registered with the practice was 149 which was approximately 1.6% of the practice population.
How the practice supported carers (including young carers).	Carers were offered annual flu vaccinations and sign posted to organisations for support.
How the practice supported recently bereaved patients.	The practice sent bereavement cards to patients they were aware had suffered a recent bereavement.

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.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes

Responsive

Rating: Requires Improvement

At our previous inspection in April 2022 we rated the practice as good for providing a responsive service and made 2 best practice recommendations:

- Provide ward rounds to patients living in care homes within reasonable time frames.
- Inform patients of their right to take their complaint to the Parliamentary and Health Service Ombudsman (PHSO) if they were unsatisfied with the practice's response, as detailed in the practice's complaints policy.

At this inspection we rated the practice as requires improvement for providing a responsive service because:

- Ward rounds for patients living in care homes had been provided within reasonable time frames.
- Patients were informed of their right to complain to the PHSO if they were unsatisfied with the practice's response to their complaint.

However:

- The National GP Patient Survey results in relation to access to appointments had deteriorated, specifically in relation to patient experience of making an appointment, and satisfaction with appointments offered.

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.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
<ul style="list-style-type: none">• The practice had access to an interpretation service for people whose first language was not English and a British Sign Language interpreter for those with a hearing impairment.• Both the main and branch sites provided level access with patient facilities located on the ground floor. A hearing loop was available for patients who had a hearing impairment. Car parks, with designated car parking for disabled people, were available at both sites.	

Practice Opening Times	
Day	Time
Opening times: The Village Surgery	
Monday	8am – 5pm
Tuesday	8.30am – 6.30pm
Wednesday	8.30am – 6.30pm
Thursday	8am – 5pm
Friday	8.30am – 6.30pm
Appointments available: Pinxton Surgery	
Monday	8.30am – 6.30pm
Tuesday	8am – 5pm
Wednesday	8am – 1pm
Thursday	8.30am – 6.30pm
Friday	8am – 5pm

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

At our previous inspection in April 2022, we found that:

- Weekly ward rounds at care homes were carried out remotely with some being delivered as late as 10pm.

At this inspection:

- We spoke with representatives from 2 care homes where the practice provided care and treatment. We found that weekly ward rounds were being provided within the care homes at a more appropriate time.
- 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.
- Patients could access appointments out of core hours through the Primary Care Network.
- Flu clinics were provided on Saturdays to support access to working age people.
- 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 a learning disability.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes

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)	41.9%	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)	29.3%	54.3%	56.2%	Variation (negative)
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)	35.8%	52.8%	55.2%	Tending towards variation (negative)
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)	53.0%	71.4%	71.9%	Tending towards variation (negative)

Any additional evidence or comments

- The National GP Patient satisfaction survey showed that patient satisfaction with access to appointments was below the local and national average in all 4 indicators. We found that patient

satisfaction with access to appointments was significantly lower than the previous year's results. To improve telephone access to the practice additional receptionists had been employed and an additional salaried GP had been recruited to enable greater continuity of care for patients. The practice had changed their appointment system so that patients had a choice of telephone or face to face appointments. Appointments could be booked up to 4 weeks in advance or on the day. The practice also signposted patients to other resources of care such as PharmRefer, a service provided by community pharmacies to provide care and treatment for patients with minor illnesses, and their on line booking system.

- We reviewed the appointment booking system and found that the next available pre-bookable appointment was available in 10 days' time. However, on the day appointments could be booked daily.

Source	Feedback
The NHS Website	There was one positive comment regarding prompt access to appointments.

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.	23
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	1

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes
At our previous inspection in April 2022 we found that patients had not been informed of their right to take their complaint to the Parliamentary and Health Service Ombudsman if they were unsatisfied with the practice's response. At this inspection we found that this information was included in the response letters to patients.	

Examples of learning from complaints.

Complaint	Specific action taken
A patient was unsatisfied because information in their records had not been updated.	The patient's records were updated. The practice updated their carer's list and monitored this on a monthly basis to prevent the issue occurring again. A formal response was sent to the patient.
A text message was sent to a patient that contained incorrect information about their health.	An acknowledgement and response letter was sent to the patient. As a result of the issue, staff were reminded that text messages should not include details about medicines or appointments.

Well-led

Rating: Requires improvement

At our previous inspection in April 2022, we rated the practice as inadequate for providing a well-led service. This was because:

- Systems to ensure accuracy and compliance to the policies were not always effective.
- Staff were not aware of the practice's vision or values and there had been no consultation with them since our previous inspection.
- Governance structures and systems were being developed, however they were not fully embedded into practice.
- Risk assessments had been completed however, it was not always clear if risks identified had been mitigated.
- Staff felt that their concerns were not always acted upon for example, managing poor staff performance.

At this inspection we rated the practice as requires improvement for providing a well-led service. This was because there had been significant improvements:

- There were systems in place to review the accuracy of policies and compliance with them.
- Risk assessments had been completed and action plans put in place to mitigate potential risks.
- Systems for managing poor staff performance had been put in place.
- Staff were aware of the practice's vision.

However:

Governance structures and systems were not fully embedded into practice. In particular systems for managing:

- Recruitment of staff.
- Medicines and Healthcare products Regulatory Agency (MHRA) and Central Alerting System (CAS) alerts.
- Authorisation of Patient Specific Directions prior to administration of a medicine.
- Completion of risk assessments for clinical staff whose immunity status to hepatitis B was unknown.
- The repeat prescribing of short acting asthma inhalers.

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.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
<ul style="list-style-type: none"> The provider had an action plan in place to address the challenges within the practice and to address the issues identified in our CQC inspections. Leaders met monthly with the Integrated Care Board (ICB) and CQC to monitor their progress against the action plan. Through discussion with leaders, there was evidence that succession planning for the practice was in place. 	

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.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
<p>At our previous inspection in April 2022 we found that:</p> <ul style="list-style-type: none"> Staff were not aware of the practice's vision or values and there had been no consultation with them since our previous inspection. <p>At this inspection we found that:</p> <ul style="list-style-type: none"> The practice's mission statement was 'Committed to Caring' and was displayed throughout the practice. Most staff we spoke with were aware of the mission statement and told us that the values had been discussed at monthly staff meetings. 	

Culture

The practice had a culture which was driving high quality sustainable care.

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

There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Partial
<p>At our previous inspection in April 2022 we found that:</p> <ul style="list-style-type: none"> • Poor staff conduct had not always been addressed. • Staff told us that they had little contact with the GP partners. <p>At this inspection we found that:</p> <ul style="list-style-type: none"> • Action had been taken to start to address poor staff conduct. • Staff told us that the GP partners were more visible in the practice and that they were approachable. 	

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

Source	Feedback
Staff interviews and feedback forms	Some staff told us working in the practice was demanding, stressful and busy. Other staff told us there was excellent team working, the staffing structure was nonhierarchical and that staff morale had improved.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
<p>At our previous inspection in April 2022 we found that:</p> <ul style="list-style-type: none"> • The safeguarding policy included inaccurate safeguarding codes and incorrect safeguarding training levels for staff. • Patients had not been informed of their right to complain to the Parliamentary and Health Service Ombudsman (PHSO) if they were unsatisfied with the practice's response to their complaint. • Systems for the monitoring of staff recruitment, monitoring that professional registrations were in date and ensuring staff immunisations were in line with national guidance had not been fully embedded into practice. <p>At this inspection we found that:</p> <ul style="list-style-type: none"> • The safeguarding policy had been updated to include accurate information. • Patients were informed of their right to complain to the PHSO if they were unsatisfied with the practice's response. 	

However:

Governance structures and systems were not fully embedded into practice. In particular systems for managing:

- Recruitment of staff.
- Medicines and Healthcare products Regulatory Agency (MHRA) and Central Alerting System (CAS) alerts.
- Authorisation of Patient Specific Directions prior to administration of a medicine.
- Completion of risk assessments for clinical staff whose immunity status to hepatitis B was unknown.
- The repeat prescribing of short acting asthma inhalers.
- The tracking of prescription stationery throughout the practice.

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.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
At our previous inspection in April 2022 we found that: <ul style="list-style-type: none">• There was no evidence that recommendations in the legionella, fire and buildings risk assessments had been actioned.	
At this inspection we found that: <ul style="list-style-type: none">• Action plans had been put in place to mitigate potential risks identified in the legionella, fire and buildings risk assessments. There was a system in place for monitoring progress against the plans.	

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.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
<ul style="list-style-type: none">The provider had forwarded 2 statutory notifications to the CQC following police involvement at the practice.	

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.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Staff are supported to work remotely where applicable.	Yes

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.	Yes
The practice had an active Patient Participation Group (PPG).	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<ul style="list-style-type: none">• Minutes we reviewed from PPG meetings demonstrated patients were informed of developments and challenges within the practice.• We found that the results of the national patient survey had been discussed with staff and their views asked about how they could improve patient experience. As a result of this, additional reception staff and a salaried GP had been employed.	

Feedback from Patient Participation Group.

Feedback
We spoke with a representative of the PPG as part of our inspection. They told us that the PPG meetings had been re-established and they had met 3 times since our last inspection. They told us the practice had shared changes made within the practice with the PPG and that patients' views were listened to though not always responded to. Due to the low attendance at the PPG meetings, the representative told us the practice planned to hold meetings both in the day and evening time to make the meetings more accessible for patients.

Continuous improvement and innovation

There was some evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes

Examples of continuous learning and improvement

- The practice used learning from significant events and complaints to drive improvements throughout the practice.
- The practice had carried out clinical audits based on new evidence and updates to improve the quality of the care they provided. In particular, compliance with the recommended vaccination schedule in patients that had received a splenectomy and anticoagulation in patients with prosthetic heart valves.
- The provider met monthly with the CQC and the Integrated Care Board (ICB) to monitor progress against their action plan to drive improvements within the practice.

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)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a 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.