

Care Quality Commission

Inspection Evidence Table

Matching Green Surgery (1-10012177836)

Inspection date: 15 June 2022

Date of data download: 26 May 2022

Overall rating: Inadequate

We rated the practice as inadequate overall because:

- Across the key questions are services safe, effective and well-led, we found that systems and processes did not ensure good governance to protect patients from the risk of harm.
- In the safe key question we found issues with safeguarding, managing and oversight of test results and information relating to patient safety, monitoring of patients on high risk medicines, prescribing concerns and the effectiveness of the management of patient safety alerts.
- In the effective key question, we found some patients had not received the required monitoring for their long term health conditions and there was a lack of effective quality assurance monitoring systems.
- In the well-led key question, we found governance systems were not effective and the practice did not regularly use data to assess and mitigate risk to patients or drive improvements. Although the practice had a vision and strategy, it was not being monitored to ensure effective care was provided to patients.

Safe

Rating: Inadequate

We rated the practice as inadequate for providing safe services because:

- The practice did not have sufficient systems and processes to keep people safe;
- Staff did not have the information they needed to deliver safe care and treatment;
- The practice did not monitor the prescribing of controlled drugs;
- The practice did not have systems for the appropriate and safe use of medicines including medicines optimisation.

Safety systems and processes

The practice did not have 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.	Partial
Partners and staff were trained to appropriate levels for their role.	Yes ¹

Safeguarding	Y/N/Partial
There was active and appropriate engagement in local safeguarding processes.	No ²
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Partial ³
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.	Partial ⁴
<p>Explanation of any answers and additional evidence:</p> <p>¹ The practice provided us with a staff training matrix which did not indicate the level of safeguarding training staff had completed. During our inspection we found that all staff had the level of training appropriate to their role, knew who the safeguarding leads were and how to raise concerns.</p> <p>The Safeguarding policy for Adults had not been reviewed at its due date in March 2022 however following the inspection we were informed the old policy was sent in error, the practice sent us the updated Safeguarding policy reviewed in May 2022.</p> <p>² The practice did not have an effective system in place to review children and adults with safeguarding concerns.</p> <p>We reviewed the patient record system and did not see documentation or reviews within the last six months for some children on child protection plans or children shared as active safeguarding patients. There was no evidence of communication between the different teams involved in these patients' care so we were not assured the practice had a system in place to check their welfare. The practice discussed safeguarding concerns during practice meetings, but we did not see evidence that children and adults were on a formal safeguarding register that was regularly reviewed. Following our inspection, the practice informed us they completed face to face reviews of all children on the safeguarding register with a plan to review looked after children within the month of the inspection. They informed us that following safeguarding meetings children will be booked in for a review.</p> <p>³ During our remote clinical searches we saw that the practice used icons on the system to identify vulnerable patients but we found some of these icons were inactive safeguarding cases. The practice informed us the system still identified children who were previously on the safeguarding register as they were on a child protection plan or looked after, but were now adults. The practice had contacted the computer system provider to resolve this issue.</p> <p>⁴ We were informed that regular discussions between the practice and other health and social care professionals had been paused during the COVID-19 pandemic and had not restarted, the provider was in the process of resuming the multidisciplinary team meetings. If patient care was required, the relevant team was contacted. Following the inspection, the practice informed us the care coordinator conducted welfare calls for vulnerable and frail adult patients.</p>	

Recruitment systems	Y/N/Partial
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Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>¹ We reviewed two clinical and two non-clinical staff files. There was a system in place to check recruitment which included keeping copies of identity checks, references, employment history and staff vaccinations. We observed clinical staff registration was checked on recruitment and we were informed this was then checked yearly. However, during our on site inspection and remote interviews the practice could not provide assurance that this was done. Following the inspection, the provider sent evidence that registration checks were carried out in May 2022 for all clinical staff.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 10 December 2021	Yes
There was a fire procedure. Date of fire risk assessment: 10 December 2021	Yes
Actions from fire risk assessment were identified and completed.	Yes

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial ¹
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 27 July 2021	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
<p>Explanation of any answers and additional evidence:</p> <p>¹ The infection control lead took the position in September 2021 however additional training or support had not been provided to assist them in their role.</p>	

Risks to patients

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

	Y/N/Partial
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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

Information to deliver safe care and treatment

Staff did not have 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 ¹
There was a documented approach to the management of test results and this was managed in a timely manner.	No ²
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	No ³
<p>Explanation of any answers and additional evidence:</p> <p>¹ The practice safety netted by advising patients to telephone the GP and appointment teams if they had not heard back regarding their referral within the expected time frame. Some staff informed us they would follow up a referral if the patient's symptoms worsened or if it was a referral they had completed. Rejected referrals were followed up as these were communicated to the practice, and administrative staff took appropriate action. The practice also followed up on 'Two week wait' suspected cancer pathway referrals.</p> <p>We reviewed the providers significant events from the last 12 months. We found the practice had documented an error which related to a delay in triaging an urgent referral by the community team. We found the practice took appropriate action and shared learning with staff.</p> <p>Following our inspection, the practice provided us with an action plan to audit referrals.</p> <p>^{2, 3} We reviewed the patient record system and found the practice did not have an effective system to manage test results. We identified outstanding tasks from July 2021 assigned to clinical staff which required action.</p> <p>The practice did not have an effective system in place to recall patients who required blood tests. Some staff told us they generated blood test forms and informed the patients via SMS, other clinicians tasked administrative staff to inform patients. As a result, there was a risk of missed patients who did not have the required monitoring, as identified by our clinical searches.</p> <p>We identified sixteen patients with hypothyroidism who had not had their thyroid function tests completed within the last 18 months and we reviewed the records of five of these patients. We found that some patients had medication reviews which identified a blood test was required in the notes, however we did not see evidence of any tasks set to contact the patient or evidence of a recall system in place. Following the inspection, the practice provided assurance that these patients were contacted to check their blood tests.</p>	

There was a lack of effective clinical oversight with the communication of test results.

We found fifteen patients having missed diagnosis of Chronic Kidney Disease (CKD) and we reviewed five of these patients. From these five patients we identified one patient test results showed there was a potential diagnosis of CKD and another two patients were identified to have CKD who were not informed. The documentation showed some of these patients had discussions about parts of their blood test results which were abnormal, however abnormal kidney function was not discussed during these consultations yet the associated task trail which related to reviewing blood test results was completed. We provided the practice with a list of these patients and were assured the patients were contacted and the summary on their notes was updated to reflect the diagnosis of the condition and that they would receive the appropriate level of treatment for their condition.

Appropriate and safe use of medicines

The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.70	0.85	0.79	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). (01/04/2021 to 31/03/2022) (NHSBSA)	4.8%	7.6%	8.8%	Variation (positive)
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 (01/10/2021 to 31/03/2022) (NHSBSA)	4.67	5.75	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	99.0‰	115.6‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.10	0.70	0.60	Significant Variation (positive)

Indicator	Practice	CCG average	England average	England comparison
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) <small>(NHSBSA)</small>	4.6‰	6.8‰	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.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
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 ¹
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 ²
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.	Partial ³
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	No ⁴
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.	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.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
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.	Partial ⁵
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
Explanation of any answers and additional evidence:	

Medicines management	Y/N/Partial
<p>During our remote interviews we were informed the clinical pharmacist completed formal audits of the prescribing and the clinician conducted clinical reviews of the patients with the Advanced Nurse Practitioner. The Advanced Nurse Practitioner informed us the lead GP was available for clinical support when required.</p> <p>¹ Not all patients prescribed repeat medicines had received a structured medicines review in the last 12 months. This included patients who were prescribed controlled drugs (medicines which can cause harm if they are not used properly and can lead to dependence and misuse).</p> <p>² The practice had a system in place for the management of information about changes made to patients' medications. A task system was used, and administrative staff allocated tasks to the clinicians to review clinical letters. We also identified an area of high risk where an urgent letter from the community team had been signed as completed by a clinician, but no action was taken to review or follow up the patient. We provided the practice with details of this patient and were assured the patient had been reviewed.</p> <p>³ Prior to the site visit, we completed several searches relating to medicines that required monitoring and review. We also completed record reviews of consultations for medication reviews. We found that for some patients, prescriptions were still issued despite them not having the required blood monitoring tests or medication reviews. There was also an ineffective system to ensure the monitoring was complete prior to the next medication review.</p> <p>We looked at the systems for managing patients prescribed direct oral anticoagulant medicines (DOACs). These patients require some blood tests, physical monitoring and a calculation (creatinine clearance) to ensure the correct dose is prescribed. Over or under prescribing of these medicines can have an adverse effect and place the patient at risk. We identified ten patients that were prescribed a DOAC who had never had a creatinine clearance calculated. We reviewed five of these patients and found there was no evidence in the record that the prescriber had checked the monitoring was up to date prior to issuing a prescription. We provided the practice with a list of these patients and were satisfied that action had been taken to mitigate the risks. The provider informed us of their plan to conduct regular DOACs audits to ensure all patients had the required calculation on the system. We identified sixteen patients with hypothyroidism who have not had their thyroid function tests completed within the last 18 months and we reviewed the records of five of these patients. For three patients, there was no evidence that monitoring had been checked prior to issuing the last prescription.</p> <p>⁴ We identified areas of high risk relating to controlled drugs prescribing. The practice did not have a system in place to prevent over ordering so did not meet the legal requirement for controlled drug prescribing. We looked at five out of the nine patients prescribed Gabapentinoids who did not have a medicines review in the last 12 months and found all these patients had received more tablets than they should have as per the National Institute for Health and Care Excellence Medicines guidance. The practice was unaware of this and very responsive to the concerns raised, we were informed all patients were booked in for a review and pack sizes were adjusted to meet the legal requirements. The provider has informed us a controlled drugs audit had started to assure prescribing was within the guidelines.</p> <p>⁵ The practice did not hold all recommended emergency medicines on site. We did not see evidence of effective risk assessments in place for the lack of suggested medicines. Staff we spoke with on the day of the onsite inspection were unable to demonstrate that the practice had considered whether the missing medicines were required however following the inspection, the provider sent us evidence which</p>	

Medicines management	Y/N/Partial
indicated discussions had taken place on what was required in the emergency drugs box and a rationale was included on the emergency drugs policy to state why items were not stocked	

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:	2
Number of events that required action:	2

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

Event	Specific action taken
Incorrect flu vaccination for the specific age range was administered to patient in error.	<ul style="list-style-type: none"> • Action: Clinician informed. British National Formulary medical information services were contacted. The practice was advised this vaccine could be used for that age cohort of patients and there were no further concerns identified. • Learning: Vaccines for different age groups were stored on separate shelves and extra checks of confirming the vaccine and age group were to be taken prior to administering vaccines.
A referral made by a clinician was rejected after three months and advised to refer the patient to secondary care. This communication was sent to the administrative team, they triaged and assigned it back to the clinician who made the referral however the clinician was on leave at that time.	<ul style="list-style-type: none"> • Action: The clinician sought advice on making an urgent secondary care referral and a follow up consultation was booked with the patient. • Learning: The practice administrative team were reminded not to assign tasks to clinicians on leave. The practice emphasised the need to continue to educate and encourage patients to follow up on their referral appointments if a delay is noted.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Staff told us the actions that were taken when safety alerts were received, and the practice kept an audit trail and action log. We did not see any documentation to evidence that staff had read these alerts. We were informed verbal checks with individual staff members to confirm acknowledgment of alerts took place.</p>	

Our clinical searches identified four females on teratogenic drugs, these medicines during pregnancy pose a significant risk of birth defects and developmental disorders. Three of these patients had not received the appropriate advice regarding the risks associated with pregnancy or a review. We did not find an effective system in place to continue the advice of highly effective contraception throughout the entire duration of treatment. The provider took immediate action and we were assured that contraception advice was now given.

We found that strengthening of the system was required for identifying patients who may need a steroid alert card in line with NHS England, National Patient Safety Alert - Steroid Emergency Card, to support early recognition and treatment of adrenal crisis in adults, August 2020.

Following our inspection, the provider informed us of their plans for patient safety alerts to be prioritised in annual audits.

Effective

Rating: Requires Improvement

We rated the practice as requires improvement for providing effective services because:

- Patients' needs were not sufficiently assessed and cared for;
- Patients who had long term conditions had not been proactively monitored throughout the pandemic;
- Breast cancer screening and bowel screening indicators remained below national averages;
- The practice had limited use of data and information from its clinical record system to drive improvements or monitor care.

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 not assessed, and care and treatment was not 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.	No ¹
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial ²
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Partial ³
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.	Partial ⁴
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
Explanation of any answers and additional evidence:	
¹ The systems in place to keep clinicians up to date with current-evidence based practice were not effective. Over prescribing of controlled drugs was identified during our clinical searches.	

² When we reviewed patients on asthma care plans it was not always clear what the plan was. The provider informed us the practice previously used free text to document the care plans and had recently changed their approach to using standardised care templates.

We took a random sample of five patients on the dementia register and found there was either no care plan or no recent care plan in place. The provider informed us the practice used free text to document the dementia care plans. It was not clear from the response or documentation what the patient received as a care plan and how this was communicated to other services such as ambulance services if there was an escalation in their care needs.

Staff were aware of prioritising all patients under palliative care and the clinician at the practice conducted most of the palliative care visits. Alternatively, the practice was in touch with the palliative care team.

³ Our clinical searches demonstrated patients' treatment was not always regularly reviewed and updated.

⁴ Our clinical searches showed that patients with Asthma were not always followed up in line with guidelines. We reviewed five records of patients who have been prescribed two or more courses of rescue steroids in the last 12 months. We found that patients were not always followed up to check response to treatment within a week of an acute exacerbation.

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- The practice did not have an effective system where GPs followed up patients who had received treatment through out of hours services for an acute exacerbation of asthma. The Out of Hours Services did not always communicate with the practice which posed a risk of the practice not being aware that patients needed a follow up unless they read the patient's notes. There was no evidence of an action plan to mitigate this risk.
- 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.
- 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 referred for ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	51	53	96.2%	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)	55	55	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	55	55	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles,	54	55	98.2%	Met 95% WHO based target

mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)				
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)	62	63	98.4%	Met 95% WHO based target

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 continued to deliver childhood immunisations during the pandemic and met the 95% WHO based uptake target.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	81.5%	N/A	80% Target	Met 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	46.0%	51.8%	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)	58.5%	62.4%	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)	42.1%	51.6%	55.4%	No statistical variation

Any additional evidence or comments

Breast cancer screening in the last 36 months for females between the ages of 50-70 was below CCG and England averages.

Bowel screening in the last 30 months for people between the ages of 60-74 was below the CCG and England average.

The practice was aware of this data and informed us they had a coding issue on their system which could have affected this. Patients were verbally advised to attend screenings and the practice was in discussions with the PCN on initiatives to educate the patient population about these screening programmes. Following the inspection, the provider informed us of an action plan to contact all patients who have not had their screening and conduct an audit into this.

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Partial ¹
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Partial ¹
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 two years

Spironolactone monitoring audit concluded some patients taking the medicines did not have the required monitoring. Action taken was to schedule 6 monthly tasks to improve the monitoring for each patient and meet the monitoring requirements.

Co-amoxiclav prescribing audit to review the patient medical notes and compare antibiotic prescribing from the year 2022 with the year 2020. One of the findings showed 8% of prescribing was inappropriate/unjustified. As a result, relevant actions were taken to discuss alternative formulary.

Any additional evidence or comments

¹ Clinical audits and quality improvement activity in the past two years had been limited due to the pandemic, in line with national guidance. The practice recently resumed this activity and shared some clinical audits completed in June 2022. Audit activity still needed to be embedded into the practice as business as usual to improve the quality of care provided.

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.	Partial ¹
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>¹ During our interviews with the Advanced Nurse Practitioner (ANP) we were informed there were regular discussions and supervision with a clinician. However, we did not see any documents to assure us there was appropriate clinical oversight. The updated training matrix did not provide assurance that the ANP had completed all mandatory training. Following the inspection, we were provided with an updated training matrix which included a complete record of the ANP's training.</p> <p>The practice had sought to assure the competency of Primary Care Network (PCN) staff that were deployed; however we saw there were gaps in this assurance system. The practice had not assured itself that staff employed by the PCN and deployed at the practice had completed all mandatory training.</p>	

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.	Partial ¹
<p>Explanation of any answers and additional evidence:</p> <p>¹ We reviewed the patient record system and identified one third of patients did not have the share in share out box ticked which gives consent to the practice to share their information to other agencies</p>	

when they are referred. The practice was unaware of this and informed us of their information sharing process during referrals completed by administrative staff where patients were informed of record sharing with community teams.

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
Explanation of any answers and additional evidence: The practice was involved in the National Diabetes Prevention Programme.	

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

Caring

Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	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

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	86.9%	85.9%	89.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)	86.0%	83.8%	88.4%	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 (01/01/2021 to 31/03/2021)	95.6%	94.0%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	83.7%	79.5%	83.0%	No statistical variation

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

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
Explanation of any answers and additional evidence: Easy read and pictorial materials were available.	

Source	Feedback
Interviews with patients.	A patient we spoke to during the inspection told us they normally had difficulty accessing the practice by telephone due to the long waiting time. However, on the day of the inspection managed to get through to the reception immediately.
NHS Website	No ratings or reviews in the last 12 months.
Practice Survey	Recent feedback shared by the practice was positive. Patients stated for telephone consultations they were called on time. Patients were satisfied with the quality and content of their appointments.
CQC Enquiries	No Enquiries in the last 12 months.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	88.5%	91.0%	92.9%	No statistical variation

	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

During the inspection, staff confirmed an audio induction loop was available to patients.

Carers	Narrative
Percentage and number of carers identified.	The practice identified 47 patients and carers, this represented 1.3% of the practice population.
How the practice supported carers (including young carers).	The practice referred carers to support agencies and offered priority appointments and flu vaccinations to carers.
How the practice supported recently bereaved patients.	Bereaved patients were signposted and referred to bereavement counselling and bereavement support groups.

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: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	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 ¹
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes ²
Explanation of any answers and additional evidence:	
¹ The nominated pharmacy requested medications on behalf of patients who had difficulty completing prescription requests. Patients with sensory impairments were identified on the system.	
² Interpreting services, spoken and non-spoken (British Sign Language) were available for patients with hearing and speech impairment if they requested. The practice informed us most patients attended appointments with carers or relatives who interpreted on their behalf.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 8.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Appointments available: BB Healthcare Solutions offered extended access appointments with a nurse or GP for general practice available at various hub clinics across Basildon, Billericay and Wickford with opening times:	
Monday	6.30pm to 8pm
Tuesday	6.30pm to 8pm
Wednesday	6.30pm to 8pm
Thursday	6.30pm to 8pm
Friday	6.30pm to 8pm
Saturday	8am to 6pm
Sunday	9am to 2pm

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

- 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.
- 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.
- Additional nurse appointments were available until 7pm on a Monday for school age children so that they did not need to miss school.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice was open until 8.15pm on a Monday and Friday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available Saturday and Sunday 10am until 1pm.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers 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 Travellers.
- 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.

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	Y/N/Partial
Patients had timely access to appointments 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	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

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	76.6%	N/A	67.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	80.2%	69.0%	70.6%	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 (01/01/2021 to 31/03/2021)	74.0%	64.2%	67.0%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	83.1%	79.4%	81.7%	No statistical variation

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.	11
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 (PHSO).	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
Explanation of any answers and additional evidence: The practice shared with us a summary of complaints received over the last 12 months. We saw from practice meeting minutes that complaints and learning were on the agenda and discussed.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Verbal complaint related to the dissatisfaction of communication from the receptionists, practice manager and clinicians.	Action: Call to complainant from the practice manager, apology and explanation given to patient. Learning: Staff educated on dealing and communicating with patients.
Verbal and written complaint referred by PHSO related to dissatisfaction of complaints handling process.	Action: Apology given to complainant for their previous tone when responding to the complaint. Learning: Practice complaints procedure updated to NHS escalation process if practice is already dealing with complaint.

Well-led

Rating: Inadequate

At this inspection we rated the provider inadequate for providing well-led services. The leadership team were unable to demonstrate there was effective governance systems and processes to ensure the delivery of safe and effective care.

Leadership capacity and capability

Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes ¹
They had identified the actions necessary to address these challenges.	Yes ¹
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence:	
¹ Leaders shared some of the challenges to quality which included the direct impact of the pandemic and the actions taken. They identified many patients did not have Wi-Fi or access to video or remote consultations so offered face to face appointments if requested.	
Patients at the practice did not always comply with blood test monitoring during the pandemic, as a result of this the practice was dealing with the back log of patients who had missed their monitoring.	
The provider informed us they experienced difficulty during the pandemic with chronic disease management, they had plans to contract with a private company to provide support in this area.	
The practice employed a part time Advanced Nurse Practitioner to assist with the increase in demand for appointments from patients.	
² The practice employed a salaried GP, and a locum GP was working at the practice for several years. Following the inspection, we were informed the partner GP would take responsibility in the absence of the Lead GP.	

Vision and strategy

The practice did not have a clear vision and there was no 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.	No ¹
Staff knew and understood the vision, values and strategy and their role in achieving them.	No ¹
Progress against delivery of the strategy was monitored.	Partial ²
Explanation of any answers and additional evidence:	

¹ Although the practice had a vision and strategy it was not being monitored to ensure effective care was provided to patients. Most staff were not involved in the development of the strategy. Some staff were unsure that the practice had a clear vision for the future.

² As part of the inspection, we were provided with recent audits, these needed to continue to be embedded into the practice to provide high quality sustainable care. Although the practice had not formally produced a strategy for their future or plans for sustainability, we saw evidence of staff recruitment to improve access and meet the needs of the population group

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.	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.	Partial ¹
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: ¹ Not all staff were aware the practice had a Freedom to Speak Up Guardian.	

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

Source	Feedback
Staff feedback questionnaires and discussions with staff.	Staff feedback was positive. Staff felt supported and able to raise concerns with the leaders of the practice. Staff described a strong team working atmosphere and a friendly working environment.

Governance arrangements

Overall, governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No ¹
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence: ¹ The practice was unaware that some of their systems and processes were ineffective as identified from the clinical searches. There was no overarching system to review outstanding workflow. The practice did not assess the quality of the system to process external letters and action them, this was a task initially completed by the non-clinical administration team and subsequently sent to clinicians if clinical action was required.	

We found the minutes from staff meetings did not always indicate time frames to complete actions identified and it was not always clear if these were followed up.

The practice used a task system to handover information between staff and tasks were separated into groups that reflected their role such as reception or nurse groups. It was difficult to assess the effectiveness of the handover as our evidence showed there was a lack of oversight in task management. This was a small practice with part time staff, which relied heavily on informal discussions and instant messaging to communicate with each other so there was not always an audit trail.

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No ¹
There were processes to manage performance.	Partial ²
There was a quality improvement programme in place.	Partial ³
There were effective arrangements for identifying, managing and mitigating risks.	Partial ⁴
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
<p>Explanation of any answers and additional evidence:</p> <p>¹We found areas of risk that were not being managed effectively including the monitoring and prescribing of controlled drugs, management of information and management of medicines. Whilst clinicians were responsible for the day to day activity, there was a lack of evidence that someone was held accountable for the risk.</p> <p>² We reviewed the task based system where staff members would allocate tasks to themselves or other staff members when an action was required. These were self-managed without any oversight to ensure tasks were completed in an effective and timely manner. As a result, the risk associated with incomplete tasks was overlooked.</p> <p>We reviewed minutes from meetings that took place at the practice, there were no clear time frames to complete actions identified.</p> <p>³ The practice had recently started to review quality improvement at the practice with a view to continue this however we did not receive a formal action plan. Audit was yet to be embedded at the practice as business as usual.</p> <p>⁴ The systems to identify, manage and mitigate risks were not always effective.</p> <p>The practice had a recall system in place for appointment recalls and following up patients who did not attend their appointment. However, our clinical searches identified this was not effective and there were gaps in the system.</p>	

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
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The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	No ¹
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
Staff were able to demonstrate the continuous measures taken at the practice to keep patients and staff safe. ¹ A receptionist's triage policy was introduced in March 2022 however staff did not refer to this when explaining how patients were triaged. There was no formal triage training, we were not assured that triage was being effectively monitored. We were told that informal discussions to review the quality of triage took place between the practice manager, clinician and the staff responsible.	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial ¹
Performance information was used to hold staff and management to account.	Partial ²
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
<p>¹ We were not assured all staff used data to monitor and improve performance. Our clinical searches identified areas that required improvement and the practice had started to take some actions following our inspection.</p> <p>² There was not an effective system to monitor staff training and competencies or record continuous professional development record. Prior to the inspection, the provider sent a training matrix which did not reflect the training of all staff members working at the practice, it also identified areas where staff training was not completed or up to date. After the inspection, the practice was very responsive to this feedback and provided evidence that they had introduced a system to review and identify staff learning needs. They implemented an updated training matrix which reflected all staff employed by the practice and mandatory training that was required. Regular oversight to ensure staff training was accurately reflected and up to date needed to be embedded as part of business as usual activity.</p>	

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

Engagement with patients, the public, staff and external partners

The practice did not involve 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).	No ¹
Staff views were reflected in the planning and delivery of services.	Partial ²
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<p>¹ At the time of the inspection, the practice did not have an active PPG. We saw information on the website about the group and how to join. During the inspection, we were informed the practice manager regularly attended the Integrated Care Board Patient Reference Group Meetings, these meetings were currently suspended due to the pandemic. We saw the newsletters were regularly published on the practice website.</p> <p>² The practice held staff meetings for non-clinical and clinical staff on a monthly basis however we identified these were inconsistent. We were informed, since the pandemic these meetings were held every two to three months. All staff that worked at the practice were part time, staff who could not attend these meetings on site were invited to attend virtually or were kept up to date with changes through informal discussions with the practice manager, meeting minutes were also circulated. Overall, staff felt there was a need for more frequent meetings to share ideas, improve learning and the quality of care delivered.</p>	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had improved their appointment availability to meet its population needs. These extra appointments were provided by the additional clinical roles employed by their PCN. We found clinicians attended monthly time to learn sessions organised by the Integrated Care Board and clinical staff attended monthly training and update sessions. At the time of the inspection the practice was in the process of transferring from e-learning for Health to the e-learning provider Blue Stream so staff can continue to access regular online and mandatory training.</p>	

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 CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

Glossary of terms used in the data.

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