

Care Quality Commission

Inspection Evidence Table

The Shrubbery Surgery (1-542226392)

Inspection date: 01 November 2022

Date of data download: 25 October 2022

Overall rating: Requires Improvement

We rated the practice as Requires Improvement overall because:

- The practice's systems for the appropriate and safe use of medicines, including medicines optimisation, required improvement.
- Our clinical record searches found improvement was required in relation to the safe management and monitoring of long-term conditions and high-risk medicines.

Safe Rating: Requires Improvement

We rated the practice requires improvement in Safe because:

- The practice's systems for the appropriate and safe use of medicines, including medicines optimisation, required improvement.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y

Safeguarding	Y/N/Partial
Explanation of any answers and additional evidence:	
The clinical rooms contained folders with amongst other useful information, child and adult safeguarding information including referral pathways and contact numbers.	
The practice had a joint adult and child safeguarding policy. It was comprehensive and clear which areas referred to child safeguarding and which applied to vulnerable adults. It had been reviewed regularly and was next due for review in December 2022.	
Examination of recruitment and other records revealed that all staff were DBS checked and had received child and adult safeguarding training to the level appropriate to their role. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)	
One of the GPs was the safeguarding lead and there was also an administrative safeguarding lead. Clinical staff attended regular multi-disciplinary team (MDT) meetings which included representatives from social services.	
Vulnerable patients such as those with learning difficulties or housebound patients had annotated flags on their records which identified them as vulnerable and why they were considered to be vulnerable. There were registers of vulnerable patient groups.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
Explanation of any answers and additional evidence:	
The provider had effective policies and processes for recruiting staff. We examined the records of five staff members which confirmed that they were being adhered to.	
The practice held records of up to date information relating to staff indemnity insurance and proof of registration with professional bodies. For example, the General Medical Council and the Nursing and Midwifery Council.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: The Shrubbery February 2022, Riverview Park May 2022	Y
There was a fire procedure.	Y
Date of fire risk assessment: One for each surgery each dated 07/06/2022. Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	
The practice produced a series of up to date health and safety risk assessments. Where there were actions identified for example, in the fire and Legionella (a bacterium found in water supplies which can	

cause severe respiratory illness) risk assessments, we were shown evidence that they had been completed by companies or individuals qualified to do so.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit:	
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
We observed the premises to be visibly clean and tidy. We saw that all relevant staff were adhering to current best practice guidance on COVID-19.	
The practice had a designated infection prevention and control lead (IPC). There was a clear and comprehensive up to date annual IPC audit. Additionally, we saw records of appropriate monthly, weekly and daily IPC checks. Where issues had been identified, there was a clear record of who was responsible for taking the action and the completion date. From previous audits there was clear recording of when actions had been completed.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
Explanation of any answers and additional evidence:	
Both temporary and permanent staff received an induction appropriate to their role. Each consultation room held a file that contained useful information such as; telephone numbers, safeguarding information and practice procedures. Policies were freely accessible to all staff on the shared hard drive and as hard copies. Locum GPs also received a separate locum pack, which included additional information such as referral procedures.	

All staff had been trained in the recognition and initial management of 'red flag' signs and symptoms including sepsis and chest pain, appropriate to their role. Staff had access to emergency equipment at both sites and had been trained in its use.

Staff told us they felt there was good cover during staff absences. Staff were trained to cover one another's roles.

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. ¹	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We completed a series of searches on the practice's clinical records system. These searches were completed with the consent of the provider, and to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance.</p> <p>New patient records were sent from one practice to another electronically GP to GP. This meant that only records that had been added to the digital record could be seen. A trained staff summariser scanned in all documents not already on the electronic notes and also ensured the coding was correct. Written records were safely on-site and subsequently sent to a secure storage facility offsite run by a specialist company. These records could be retrieved on the day if necessary.</p> <p>Digital records access was available to the local GP federation, who ran an extended hours service and home visiting service. Patients were told that they had access to the records and consent was obtained for their use.</p> <p>We saw that the practice had a reliable system for referrals including two week wait referrals for potential cancer diagnoses. We saw that there were built in safeguards to ensure that patients received timely appointments.</p> <p>We also saw that there was a reliable system for managing documents that arrived at the surgery. All documents were scanned in to the system. All documents were seen by a clinician in digital or paper form and there was a system to ensure that each was reviewed by the GP who returned it to</p>	

specific administration staff with the actions required. These actions were recorded on the system. Documents were managed in a timely way.

There was a system for managing test results in a timely manner. If GPs were away, then their test results were shared amongst the remaining GPs and including the duty doctor.

Appropriate and safe use of medicines

The practice had some systems for the appropriate and safe use of medicines, including medicines optimization however improvements were required.

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)	1.01	0.85	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)	11.8%	8.9%	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)	5.72	5.77	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	159.8‰	132.5‰	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)	0.47	0.61	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	7.6‰	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.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	P
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. ¹	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. ²	P
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	P
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	P
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>We looked at nine patient group directions (PGDs) and found that all of them had been signed by the appropriate staff, but had been completed incorrectly. None of the PGDs we looked at had blank areas crossed through to prevent the addition of more staff names after the authorising manager had signed off the PGD. We saw that although most nurses' signatures had been added prior to the authorising manager, some had been added afterwards. This meant that those nurses had not therefore been appropriately authorised by the GP to use the PGDs to administer medicines.</p>	

Medicines management	Y/N/Partial
<p>After the inspection, the provider wrote to us with evidence that the PGDs had been completed correctly. Staff had been made aware that a new signature page needed to be completed for new nurses who joined the practice and required countersigning by the GP.</p> <p>We looked at the designated refrigerators for the storage of vaccines at Riverview Park Surgery and The Shrubbery Surgery. We found vaccines were appropriately stored and transported in line with UKHSA guidance at both practices. This helped ensure they remained safe and effective. We saw fridge temperatures were monitored daily, We found that at Riverview Park there was clear written guidance for staff to follow and an incident form to complete if the fridge went out of range. There were clear records kept of any cold chain changes, such as when new stock of vaccines or other refrigerated medicines were received and put into the fridge. The fridge was locked at all times. All medicines were stored securely and appropriately.</p> <p>However, at the Shrubbery Surgery records showed that there had been many occasions where the temperature of the fridges had been recorded as being outside the acceptable limits of two and eight degrees centigrade. Between February and October 2022, one fridge had been out of range on six occasions during that time, The other fridge had been out of range daily between 29 March to 12 May 2022 and on eight occasions between 16 May and 19 August 2022. We could not see any written guidance for staff to follow in the event that fridge temperatures were out of range. There was no record of any action that had been taken and although there were blank incident forms beside each fridge, the practice did not produce any completed forms.</p> <p>After the inspection, the practice provided us with an overview of the actions they had taken in relation to the above issues that had been immediately implemented. We were told that they had carried out an investigation and risk assessment. Internal data loggers had shown that there were no extended periods when the temperatures were outside the recommended range. For example, after stocking the fridge. Monitoring processes had been amended and we also saw that the issue was discussed at the next clinical meeting at which it was noted that as well as the changes, further training was to take place for all staff involved. We also saw that any meetings to discuss changes in process or procedure were always to be recorded.</p> <p>We saw that both practices held appropriate emergency medicines and equipment. There were no issues with the provision' storage and monitoring of emergency drugs and equipment at Riverview Park Surgery and all were in date. However, although emergency drugs and a defibrillator were provided, in date, stored and checked appropriately at the Shrubbery Surgery, we found that the oxygen cylinder although containing oxygen was out of date and we could find no written record that it was being regularly monitored. Other emergency equipment was in date and where it needed calibration was up to date with that, but there was no record that these were being monitored regularly. We did see evidence that the practice were aware that the oxygen was out of date and had ordered a new cylinder which was due to arrive the day after the inspection.</p> <p>After the inspection we were sent evidence that the oxygen had been replaced and that checks both weekly and after oxygen use were to be recorded. The practice was to keep a reserve supply of oxygen across both sites. The issue had been discussed at a practice meeting and protocols revised.</p> <p>We completed a series of searches on the practice's clinical records system. These searches were completed with the consent of the provider, and to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance.</p>	

Searches were run on patients taking DMARDs (Disease-modifying antirheumatic drugs) a group of medicines used in the management of rheumatoid arthritis and some other illnesses.

- We reviewed the clinical records of five patients taking Azathioprine, one of the medicines to treat rheumatoid arthritis. The searches showed that of 32 patients on the medicine, 29 patients had received appropriate monitoring and three potentially had not. Analysis of five patient records including the three that had not apparently received monitoring showed that in the case of the three patients who potentially had overdue monitoring, efforts had been made to reduce risk and encourage the patients to attend for monitoring. Letters were sent and the amount of medicines prescribed in these cases was currently reduced (quickly down to weekly), so that repeat prescriptions would have to be issued much more frequently until they attended for monitoring. If patients didn't respond to further requests the GP would consider taking consultant advice on stopping the medications. Patients were advised why it was important that they attend. This was in line with the practice policy.
- We carried out clinical searches in to the management of patients on a newer class of medicines for thinning the blood (DOACs). These required monitoring that included blood tests and the recording of weight and height. We found that of the 434 patients on the medicines, 168 had potentially not had the required monitoring. We looked at five records in detail of patients that had potentially not had the required monitoring and found evidence that four of the five patients had very recently been invited for monitoring just prior to the searches being carried out. The fifth was under the care of the hospital and there were no concerns. It was difficult to establish the indication for prescribing sometimes, due to unclear coding in patient problem lists.

The practice was informed of the concerns when the searches were carried out. An action plan was produced and shown to us at the on-site inspection (and a copy sent to CQC afterwards). On the day of the inspection, the provider told us that had identified all the patients who were not up to date with monitoring and had sent invites to attend to resolve this. We were also told that the practice were initiating appointments specifically so that patients' heights and weights could be measured and blood tests could be carried out where required. We understand from the practice that these were now operating and that where patients can't come in, they are being phoned to ascertain their height and weight. Records were also to be reviewed with respect to coding. They had allocated responsible persons and timescales to review progress and achieve their aims with the first progress review at the end of November. There were plans to carry out follow up audits.

- Clinical searches of patients being prescribed Gabapentinoids, medicines from a group mainly used to treat nerve pain showed that 215 out of 269 patients on these medicines were overdue for a medication review. We reviewed five records from the cohort of 215 in detail and in three of the five records sampled there was no record of a recent review. For three patients it was difficult to establish a clear indication for the prescription.

At the on-site inspection, the practice showed us an action plan. They had identified and contacted the patients and medication reviews for this group of patients had already commenced. There were responsible persons identified in the action plan and dates to review progress (December 2022) and complete the reviews by (March 2023).

Medicines management	Y/N/Partial
The quality of sampled medicine reviews was considered to be fair. Often however, they were only partially coded. For one patient there was no diary recall existing for high risk medicine monitoring, although monitoring was being carried out.	
The practice produced a revised action plan shortly after the inspection with respect to medicine reviews in which they had revised the prioritisation criteria and widened the scope of patient groups requiring regular structured medicine reviews.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	3
Number of events that required action:	3
Explanation of any answers and additional evidence: Staff knew what significant events were and how to raise them. The issues would be dealt with urgently by the practice manager and partners as appropriate and would then be discussed at monthly clinical meetings which were minuted. We saw that learning was cascaded to staff as appropriate.	

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

Event	Specific action taken
A patient was prescribed a new medication that their carer queried.	This was investigated by the clinical pharmacist and the practice manager. It was determined that new medicines had been prescribed to a patient of the same name, but it had been the wrong patient following hospital discharge. A policy for double checking when patients have the same name was introduced. Learning was cascaded to staff.

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

We interviewed several staff members and saw that there was an effective system in place for the management of safety alerts such as MHRA (Medicines and Healthcare products Regulatory Agency) alerts. The alerts and the actions taken were recorded on a spreadsheet. They were also discussed at clinical meetings with minutes of the meetings being readily available to appropriate staff. Historic MHRA alerts were also reviewed when new patients were registered with the practice.

We saw examples of actions taken on recent alerts whilst on-site both for recent alerts and also historic alerts.

The provider kept a spreadsheet of safety alerts and the actions taken and was able to demonstrate that all relevant safety alerts had been responded to. However, when remote searches were carried out, we reviewed patients who were prescribed a combination of medicines that could be used to treat high blood pressure and heart failure. We found 57 patients who had been prescribed these medicines; 15 of which were identified as potentially not having had the required blood test in the last six months. From these we reviewed five patient records and found all were very overdue for monitoring. although several attempts had been made to engage two of the patients. Several of these patients were on multiple other medications with long intervals since a general medication review. All the patients had been sent recall letters to attend for this monitoring not long prior to the remote searches taking place,

During our site visit the practice management team provided us with an action plan they had set up in relation to the above patients. We saw the plan detailed who would be the responsible persons, what monitoring would be required and the timescale by which these would be completed by. They had already sent out recalls to all the patients requiring monitoring.

Effective

Rating: Requires Improvement

We rated the practice requires improvement in Effective because:

- Our clinical record searches found improvement was required in relation to the safe management and monitoring of long-term conditions and high-risk medicines.

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 always assessed, and care and treatment delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	P
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. ³	P
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence: The practice had a robust system of recall for patients with Long Term Conditions	

Effective care for the practice population

Findings
<ul style="list-style-type: none">• 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 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.

During our inspection, we completed a series of searches on the practice's clinical records system. These searches were completed with consent and to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance.

- We looked at patients who had been diagnosed with chronic kidney disease stage four or five who had not received a blood test in the last nine months. Our search identified 32 patients diagnosed with chronic kidney disease stage four or five; seven of which had potentially not received a recent blood test. Analysis of five sets of records from the group that did not appear to have received monitoring revealed that all of the patients were being managed appropriately.
- We looked patients diagnosed with diabetic retinopathy whose latest blood test indicated high blood glucose levels over the last two to three months (diabetic retinopathy is a complication of diabetes, caused by high blood sugar levels damaging the back of the eye. It can cause blindness if left undiagnosed and untreated). The total number of patients with diabetic retinopathy was 21. The total number of patients with diabetes was 1033. Only 2% of the diabetic patients had poor sugar control, which suggested good overall management of this condition. Of the five records of patients with retinopathy reviewed in detail, four patients were having reasonable diabetic management. Attempts had been made to engage the fifth patient, but they were also receiving secondary care from the hospital.
- However, we looked in detail at the records of patients with asthma who had been prescribed two or more courses of rescue steroids in the last 12 months. Our search identified 717 patients on the asthma register; 47 of which had been prescribed two or more courses of rescue steroids. From these we reviewed five patient records and found that there were aspects inconsistent with best practice in the management of acute asthma exacerbations. We found that of the four patients that required acute follow up, none had received one following any of the occasions when rescue steroids were prescribed. Additionally we found examples of infrequent face to face assessment and only one occasion when the doses of regular inhaled steroids were altered to try to prevent further acute exacerbations. There was no record that patients who were eligible for steroid alert cards were provided with one. There were also some examples of sparse documentation.

The findings of the searches were shared with the provider. When we attended the on-site inspection they told us they had reviewed the records identified by the search and were booking appointments for patients who required a review. We also saw an action plan which explained how the provider would monitor and improve their systems and processes. The action plan

allocated responsible persons to ensure it was carried out and dates for initial review of how it was progressing and completion of the plan. We saw minutes from a recent clinical meeting held after our inspection which showed discussion about this had taken place to help ensure best practice was followed.

- Searches showed that only two out of 717 patients with asthma had received large numbers of reliever inhaler prescriptions in the past year. This may be associated with effective preventative management for most patients with asthma.

Management of people with long term conditions

Findings

- We ran clinical searches for patients with hypothyroidism who had not had thyroid function test monitoring for 18 months. There were 462 patients identified on the hypothyroidism search, 43 had not had monitoring for at least 18 months which included 15 patients whose last blood test result was abnormal. We looked at five patients in the group of 15 with a previously abnormal result and all five were still being prescribed the medication. Diary reminders existed, but we could not see evidence that they had been recalled.

When we carried out the on-site inspection, the practice showed us their action plan which was designed to resolve the issues identified by the searches and told us that all patients requiring monitoring had been contacted via letters or texts to ask them in for blood monitoring. They would be followed up again in two weeks if they did not respond. Persons responsible for monitoring and completing the action plan were identified and the administration team were also involved. Review and completion dates to achieve full compliance were set as well as dates for regular re-running of the searches.

- Searches showed 290 patients had a potentially missed diagnosis of Chronic Kidney Disease (CKD). Of the five records sampled, four were missed diagnoses and not coded as CKD or having appropriate monitoring. However, three out of four were prescribed appropriate medications due to overlap with other medical conditions. The fifth patient was under hospital care.

Additionally:

- Patients with long-term conditions (LTC) 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. Via regular multi-disciplinary team meetings.
- Patients who did not attend their LTC review appointments were contacted by the service including being contacted by telephone.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Although the practice had a system for calling and recalling patients with long term conditions the system was not always effective in ensuring that those patients received the monitoring and reviews in line with best practice.
- 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.

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)	174	183	95.1%	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)	186	192	96.9%	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)	184	192	95.8%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	183	192	95.3%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	169	192	88.0%	Below 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

Children and young people were always offered appointments on the day if appropriate.

Childhood immunisations were carried out in line with the national childhood vaccination programme.

NHS England results (published in March 2021) showed that uptake rates met the World Health Organisation (WHO) target for four indicators. One indicator was slightly below the 90% minimum target;

the practice told us they thought this was due to an increase in vaccine concerns amongst their patients. The practice had a robust, embedded system for calling patients in for immunisations which was supplemented by additional contact via telephone, texts and letters where needed. Staff would make efforts to discuss the benefits of immunisation with parents and guardians where appropriate.

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: 30/06/2022) (UK Health and Security Agency)	72.9%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	75.5%	63.4%	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)	69.0%	68.0%	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)	55.6%	56.4%	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
The practice are aware that they are not meeting the 80% target for cervical screening. They demonstrated a thorough system of checking whether patients have been appropriately called or whether they should be deferred (for example pregnant or recently had a baby). If patients did not attend their appointments, the provider told us they sent recall letters/text messages to remind patients of the need to book an appointment.

Monitoring care and treatment

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

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

An audit was carried out in March 2022 looking at Lithium monitoring within the practice. This included the measurement of height and weight as well as Lithium levels in the blood every three months and other appropriate blood test monitoring. As a result, the practice had reviewed and produced a system

for regular monitoring of lithium, including monthly searches on the computer practice management system. Details were included in their written policy on high risk drug monitoring. The practice had repeated a second cycle of the audit in September 2022. Findings showed the revised system of monthly searches had been maintained. All patients were prescribed their medicines by brand (it is important that in the case of Lithium, patients are consistently prescribed medicine from the same manufacturer) and patients were being regularly checked and monitored. They had also identified they could improve the way in which they obtained patients' height and weight.

The practice had also recently carried out the first cycle of an audit of the monitoring and management of methotrexate (a medicine that is used to treat rheumatoid arthritis and other autoimmune diseases) and had made changes to their processes. We saw the provider had plans to conduct a second cycle audit in six months' time.

The practice ran an audit in to early cancer diagnosis in the last six months of 2021.

An audit of 80 documents sent in to the practice by secondary care, patients and allied health professionals were analysed in March 2022, by a clinician in response to a complaint by a patient to assess how effective the current system for document management was. The results were generally positive but did raise suggestions as to how the system could be further improved. These included, amongst others, all letters with a diagnosis being checked by administrative staff to ensure the coding was correct (the practice had some issues with coding following the switch to a different software system).

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:	

Analysis of training records showed that staff had received training and ongoing supervision and support appropriate to their roles. There was a training record that allowed staff to see what they had completed and what they needed to complete. The system reminded staff when training was due and this was reinforced by the management team, who would also send reminders when training needed to be completed. Time was made available for staff to complete training modules and there were biannual training afternoons when the practice was closed (and emergencies covered by another service) for additional staff training and team meetings (when a community hall would be hired).

Non-medical prescribers and other non-medical staff with extended roles had been trained to the appropriate level and all received appropriate supervision by a named GP. If the clinician worked across both sites they had a named mentor at each site. A GP would be present in the surgery for advice and would discuss all patients that had been seen in the surgery that session with new non-medical clinicians. These staff members kept records of the consultations and discussions. All non-medical clinicians told us that they were well supported.

Some of the staff were employed by the Primary Care Network (PCN) and they also had mentors within the PCN who they met with on a regular basis, but their primary supervision was within the practice.

We saw that there was a structured induction programme for new staff and structured annual reviews. Staff told us that if they had issues that they wished to raise, including training requests, they could arrange a face to face discussion with a line manager at any appropriate time.

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
All staff that we spoke to confirmed that they worked very well as a team. Staff were trained to cover other staff member's roles if they were absent.	
Records of meetings of the Multi-Disciplinary Team (MDT) showed that there was close co-operation between the practice and other services that led to a high standard of care for those patients that required additional care, help and support.	
If a patient was seen by the out of hours services, the practice received information about the contact, action taken and outcome, the next morning.	
If a patient was seen by the paramedic visiting service run by the local GP federation, they would either phone the GP if urgent, or advice was required. If it was less urgent, the result of the consultation was emailed to the practice and put in the patient's records.	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence:	
We saw that information was available for patients in the waiting room and on the practice website. This included health and wellbeing advice and signposting to local support groups.	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Y
Explanation of any answers and additional evidence:	
We looked at the records of two patients with DNACPR decisions. We found there were clearly documented reasons for the DNACPR decisions that were not discriminatory or based on assumptions about the person's quality of life, and there was a record of a discussion with the person (and their representative, where appropriate). We were told that a copy was retained by the practice and one by the care home (if that was the patients place of residence).	

Responsive

Rating: Good

The data and evidence we reviewed in relation to the responsive key question as part of this inspection did not suggest we needed to review the rating for responsive at this time. Responsive remains rated as Good.

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	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
Explanation of any answers and additional evidence:	
The practice had remained open throughout the pandemic providing a range of appointments, including; face to face appointments, telephone consultations and video calls.	
There were multiple appointment types available, including face to face, telephone and video consultations. There was an online service available whereby patients could ask questions via the website and receive answers within 48 hours. Patients were able to book appointments in person, on the telephone and via the website. The practice had a system whereby trained 'navigators' would ensure patients were directed to the most appropriate person to respond to their immediate needs. The practice additionally offered evening GP surgeries on Monday, Tuesday and Wednesday from 6.30pm to 8pm.	
The Primary Care Network (PCN) ran an extended access Saturday morning GP and phlebotomy services which the practice patients had access to.	

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)	43.1%	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)	46.1%	48.6%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	47.2%	48.2%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	69.9%	68.2%	71.9%	No statistical variation

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: Leaders held regular meetings with appropriate staff members. These would include partners' meetings where such issues as finance and business plans would be reviewed and clinical meetings where current clinical issues and guidelines would be discussed. These would also include quality outcome framework (QOF) discussions where issues of quality improvement would be reviewed and complaints and significant events were discussed. There was an annual complaints and significant events meeting when all of the issues for the year were reviewed. There were also meetings held for administrative and reception staff. Staff told us that the leadership at both sites (GPs and managers) were all approachable and accessible and there was an open door policy. Staff also told us there was appropriate managerial oversight across both sites.	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: The practice had a mission statement and practice values which was displayed in the waiting room, reception and also available on the practice shared drive. Staff we spoke with knew and exhibited the mission statement and core values of the practice.	

Culture

The practice had a culture which drove high quality sustainable care

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	N
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	
The practice did not have a Freedom to Speak Up Guardian, but there was a clear whistleblowing policy which staff understood. They were also aware of the process should they wish to raise a concern. Staff also reported that they were comfortable talking to all leaders and managers in the practice.	

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

Source	Feedback
Staff feedback forms and interviews.	All staff that filled in a feedback form or were interviewed told us that they were well supported by the GPs and management team. There was an open door policy and all were considered approachable. Staff also felt that they supported one another well as a team and that their opinions were sought and listened to.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence:	
There were governance structures which were kept under review and which were readily accessible to all staff. For example, there was a suite of policies that had been tailored for each site where appropriate.	

Each was reviewed annually and the date for the next review were recorded on the front page of each policy.

Staff that we talked with were clear about their roles and were aware of the roles of colleagues.

The practice told us that they continued to work throughout the Covid-19 pandemic and followed the Covid-19 guidance. For example, they continued to conduct long term condition reviews. The provider carried out regular review meetings to assess their position and felt that they no longer had a backlog. Where patients were waiting for hospital appointments and clinicians felt that a patient needed to have their appointment expedited, both clinicians and administrative staff would ensure that the hospital were made aware.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	P
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<p>From our clinical searches, we saw that long term condition and high risk drug reviews and monitoring of patients were not always being completed in line with best practice guidance. We raised this with the provider and were sent a clear action plan that was being implemented to ensure all reviews and monitoring would be managed effectively.</p> <p>We found that improvements were needed at The Shrubbery Surgery in relation to the monitoring of vaccine fridges and some emergency equipment.</p> <p>After the inspection the practice sent us action plans to resolve these issues that had been immediately implemented.</p>	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y

Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:	
The practice carried out audits to help identify problems and make changes to help improve quality. They constantly analysed their performance in carrying out appropriate long term condition reviews and held regular meetings to assess how well they were doing in relation to the quality targets set within the quality outcomes framework (QOF). Clinicians were supported in this by specific administration staff. Other clinical issues would also be discussed at the monthly meetings such as new alerts or guidelines.	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	
Patient records were recorded and saved on to a nationally recognised GP records software programme which was protected by appropriate digital protection software. Records could be accessed by some outside health agencies such as the extended access service and the home visiting service with patient consent. The access was protected by digital security and password protected. Within the practice it was only accessed by staff who had been appropriately trained and signed confidentiality documents. Staff members could only access the records to the level appropriate for them to carry out their role. To access the records staff used a personal smartcard and password. Staff described how they secured their computers when moving away from their desk by logging out and removing their card. All rooms were lockable.	
When the practice received paper records for new patients, they were locked in a secure cupboard whilst they were being held for processing, after which these and all other paper records were held in secure storage offsite by a specialist company.	

Patients could access services online such as repeat prescription requests, appointment booking and the econsult service. Patients required a user name and password and could only access appointments and records personal to themselves.

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	P
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Explanation of any answers and additional evidence:

Prior to the Covid-19 pandemic, the patient participation group (PPG) was very active and we saw examples of minutes when several staff members and a large number of committee members attended. During the pandemic the PPG did not meet however the practice told us they planned to restart the PPG in January 2023. We were told the practice have now texted patients who have expressed an interest in restarting the PPG.

The practice attended regular multi-disciplinary team meetings in which they worked with representatives and professionals from a variety of agencies including social services, a care co-ordinator, the community matron, community nurses, the frailty nurse and third sector organisations.

The practice worked closely with a group of GP practices within their Primary Care Network (PCN) and linked with other practitioners in order to provide additional services for patients. These include the provision of staff such as a clinical pharmacist, pharmacy technician and paramedic clinician.

The practice had an open culture and staff told us that they were encouraged to share ideas to the management and felt comfortable doing so. We saw minutes from a staff meeting which encouraged staff to let the management know if they had suggestions for improvements regarding day to day activities. We also saw changes to processes were agreed by clinicians in response to administrative staff requests.

Feedback from Patient Participation Group.

Feedback
We spoke with a former member of the patient participation group prior to the Covid pandemic when the PPG stopped its activities. They told us that they had received a text from the practice asking whether they would be interested in being involved if the PPG was restarted. We were told that the PPG had started relatively small but became so large that a community hall was required to hold meetings. The committee was initially made up of older patients, but younger patients had joined and the demographic had become more mixed. At least one manager always joined the meetings. The agenda was set by the chair person (a patient member) and the practice added issues as well. Additional points could be raised on the day under 'any other business' and if the practice couldn't answer immediately, the point would be added to the next agenda. Meetings were held every two to three months. We saw the practice had responded to issues raised by the PPG. For example, implementing a new telephone system which

informed patients where they were in the queue. We were told by the former PPG member that they thought the PPG grew quickly because people felt the practice listened and responded to them.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff told us that they can request training both at their annual appraisals and at additional face to face meetings. We were told that where possible and if appropriate, the training request would be granted. There was a comprehensive online suite of training accessible to all staff that provided training in all mandatory subjects as well as additional subjects. Staff could monitor their own training and all training was monitored and reviewed by managers. This was supplemented by training afternoons involving all staff.</p> <p>Issues were discussed at meetings such as the complaints and significant events meetings and learning was cascaded via further meetings amongst specific staff groups. We saw minutes were recorded and readily available to all staff.</p>	

Examples of continuous learning and improvement

One nurse had recently been encouraged and supported to become a nurse prescriber. One of the GP partners was trained to teach doctors in their second year after qualification as part of their junior doctor foundation training. Another staff member had started as a receptionist but was now trained to be a health care assistant and phlebotomist.

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.