

Care Quality Commission

Inspection Evidence Table

Willow Tree Family Doctors (1-2555604675)

Inspection date: 24 August 2022

Date of data download: 15 August 2022

Overall rating: Requires improvement

At this inspection we identified concerns relating to the safe, effective and well-led key questions and rated the practice as requires improvement in these key questions. We rated this practice as requires improvement overall. Please see below for detailed findings.

Safe

Rating: Requires improvement

At this inspection, we found the following areas of concern:

- We found issues with the monitoring of patients on some high risk medicines.
- We found that medication reviews were not always completed in appropriate detail.
- We found that the system for managing and acting on Medicines and Healthcare Products Regulatory Agency (MHRA) alerts was not always effective.
- We found gaps in the training records of two clinical members of staff who had overdue Mental Capacity Act training.

The practice was therefore rated as requires improvement for providing safe services.

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

Safeguarding	Y/N/Partial
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
<p data-bbox="57 629 810 663">Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li data-bbox="108 712 1525 857">• We found that the safeguarding policies for adults and children were up to date and contained the appropriate information for staff to be aware of the processes to follow in the event of safeguarding concerns. The practice also had a policy regarding looked after children. Policies were easily accessible by staff members on the practice's web-based platform. <li data-bbox="108 898 1525 969">• Staff members we spoke with were familiar with the practice's safeguarding policies, safeguarding lead and were confident in the method of escalation if a safeguarding incident arose. <li data-bbox="108 1010 1525 1709">• At our site visit, we spoke with the Safeguarding lead who told us about the practice's systems and processes for managing safeguarding concerns. The lead told us that the practice had a comprehensive system where they were the designated lead each day for safeguarding, with a duty doctor acting as a deputy each day. The practice manager acted as an administrative lead, supported by the practice's workflow team. The lead told us that all staff received a comprehensive induction when they started working at the practice. The practice held adult and children safeguarding risk registers, including registers for children in need, grey case (vulnerable children who had not met the threshold for a safeguarding referral), looked after children, children subject to child protection and a safeguarding adults risk register. The lead told us that these registers were regularly reviewed and that during the Covid-19 pandemic lockdown, they had been comprehensively reviewed to ensure that all records were up to date. The lead informed us that they regularly attended multi-disciplinary conferences about safeguarding, which had been held remotely since the Covid-19 pandemic. The lead told us that they acted as a failsafe for the practice, and that the practice had a low threshold for checking, to ensure that no safeguarding cases were missed. They told that the practice had a mobile population and that the practice was vigilant and alert to safeguarding risks. The lead informed us that staff at the practice had received domestic violence training and that staff were given in house training updates on safeguarding and Female Genital Mutilation (FGM). Patients safeguarding concerns coded and were identified on the clinical systems. <li data-bbox="108 1749 1525 1933">• The practice discussed safeguarding as a standing agenda item at clinical meetings which were held monthly. The safeguarding lead presented at the meetings. The clinical lead met with the Primary Care Safeguarding Lead and had email contact with the Local Authority Safeguarding Team (adult and child). The safeguarding lead would cascade any safeguarding updates and guidance from the local authority to staff via the web-based platform used by the practice. 	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> Clinical staff told us about the processes for monitoring potential patients at risk of FGM. The practice had a separate FGM policy, which detailed the practice's processes for managing risks relating to FGM. Clinicians liaised with other health professionals where required. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We reviewed staff files for two clinical and two non clinical members of staff. We found that appropriate recruitment checks had been undertaken prior to employment. We found that staff records were well managed. The practice told us that it was in the process of transferring staff training records to the web-based platform it had put in place from February 2022. We found gaps in the training records of two members of clinical staff who had outstanding Mental Capacity Act training. The practice told us that both members of staff had been reminded to complete this training. We found that staff vaccinations were mostly up to date in line with UK Health Security Agency (UKHSA) guidance. We identified some gaps in relation to staff member immunisations. Following our site visit, the practice provided us with evidence of this missing information apart from one member of clinical staff, who had not provided evidence of tetanus, polio and diphtheria vaccinations. The practice told us that the member of staff had verbally confirmed that they had received these immunisations and was awaiting evidence of this. 	

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 August 2022	Y
There was a fire procedure. Date of fire risk assessment: 22 September 2021	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> A comprehensive fire risk assessment was completed by an external company in September 2021. The practice confirmed that actions in this risk assessment had either been completed or were in the process of being completed. We saw evidence of internal fire drill and fire alarm checks being routinely carried out. 	

- The practice was spread over three floors (with two used by patients) and had three evacuation chairs to assist with the evacuation of patients with mobility issues down the stairs in the event of a fire and the lift being out of use.
- At our site visit we found a set of weighing scales in one of the consultation rooms which did not have a recent sticker indicating that they had been calibrated recently. The practice informed us following our inspection that they had been removed from the room and that there was either an error by the calibration company or that the scales had been moved to this room from elsewhere.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 12 August 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice had an up to date infection prevention and control (IPC) policy and we saw evidence that an internal IPC audit had been carried out on 12 August 2022. We found that the premises were well managed with an effective system for managing IPC. We saw evidence that IPC was discussed at staff meetings. Staff we spoke with were aware of their IPC responsibilities. The practice nurse conducted IPC audits every six months and completed separate sharps and hand hygiene audits. • We saw evidence of a legionella risk assessment that had been carried out by an external company on 16 December 2021. Legionella bacteria can cause a pneumonia-type illness called Legionnaire's disease. The practice confirmed that all actions identified in this risk assessment had been completed. • The practice had a policy for cold chain management and a process in place for the checking and monitoring of fridge temperatures. The practice maintained a fridge temperature log and the internal and external thermometers on the two practice fridges were checked throughout the day. We found all medicines stored within the fridges to be in date. 	

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: <ul style="list-style-type: none">• Staff we spoke with were aware of what action to take in the event of a medical emergency and were aware of how to escalate concerns and raise an alarm. The practice had a panic alarm policy which contained information about the correct process for staff to follow in the event of an emergency, which was available on the web-based platform used by the practice which was accessible to all staff.• The practice had an anaphylaxis protocol and an emergency incident handling protocol which were available as guidance for staff on the web-based platform.• The practice had touch screen 'pods' which were available for patients to use, one on the ground floor and one on the second floor. Patients were able to access information on the pods, including patient information leaflets. The practice also had an information table on the ground floor with a computer that could be used by patients to access information. This table also held patient information leaflets including on dementia, cancer for men, Alzheimer's, carers and shingles.	

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.	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> <ul style="list-style-type: none"> We observed that clinical data was kept securely at the practice. The practice had a scanning and coding protocol and a summarising records protocol. The practice informed is that it had summarised 95% of all GP to GP new records. Summarising and coding at the practice was completed by the dedicated workflow team. The practice had a referral policy and protocol, which set out the practice's process for managing two week wait referrals. The practice had set up safety netting within its clinical system which was triggered by a two week wait referral code. The set a diary entry for three weeks after the referral date. The practice ran weekly searches on its clinical systems to check that every patient who had been referred under the process had received an appointment. The practice would contact a patient if no appointment had been received and would chase the two week wait referral team. The practice contacted patients by telephone to ensure that they had attended their appointment. The practice had a cervical screening policy and protocol which included information about failsafe arrangements and the practice had a system in place to ensure that results were followed up in a timely manner. 	

Appropriate and safe use of medicines

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

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)	0.67	0.57	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)	11.6%	9.1%	8.8%	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	5.58	5.54	5.29	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	54.3‰	57.8‰	128.2‰	Variation (positive)
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)	0.08	0.47	0.60	Significant Variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	3.7‰	4.8‰	6.8‰	Tending towards variation (positive)

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	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.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y

Medicines management	Y/N/Partial
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p data-bbox="57 674 810 719">Explanation of any answers and additional evidence:</p> <ul data-bbox="108 752 1513 864" style="list-style-type: none"> <li data-bbox="108 752 1513 864">• We found that monitoring of patients prescribed some high risk medicines was not always completed appropriately as required in the time frames specified by the National Institute for Health and Care Excellence (NICE) guidelines. <p data-bbox="156 898 1513 1603">We found that patients prescribed Azathioprine (a type of immunosuppressant used to calm or control the body's immune system and used to treat inflammatory conditions including rheumatoid arthritis, Crohn's disease, ulcerative colitis, severe inflammation of the liver, skin or arteries and some blood disorders) had not always had the appropriate monitoring. Our searches indicated four patients (out of a total of 14 patients prescribed Azathioprine) who had not had the required monitoring. We reviewed these four patients and found that blood tests had been completed by specialists but had not been documented in an accessible format in the clinical records system. We could not find evidence of shared care protocols in the clinical system. Following the clinical searches, the practice told us that it had reviewed the patients identified and had found that all patients were safe and appropriate, other than one result which had been received the day after the clinical searches. The practice downloaded two results from the hospital records which were carried out in the correct time period and one patient had received his medicine from the hospital and not from the practice and so should not have been detected in the clinical search. The practice told us that all tests for Azathioprine monitoring, and other tests performed by hospital clinicians, were in an accessible format and that the practice had direct access to the hospital results system via the ICE system (a system that linked GP practices to laboratories) at the time of prescribing. The practice provided us with a copy of the shared care protocol, which was accessible through a link in the data template in every patient record where they were prescribed disease-modifying antirheumatic drugs (DMARDs).</p> <p data-bbox="156 1637 1513 1861">We found that patients prescribed Angiotensin converting enzyme (ACE) inhibitors or Angiotensin II receptor blockers (ARBs) (medicines mainly used in the treatment of high blood pressure and heart failure) had not always had the appropriate monitoring. Our searches indicated 107 patients (out of a total of 1533 patients prescribed ACEs or ARBs) who had not had the required monitoring. We reviewed five of these patients and found that monitoring was overdue in four of the patients.</p> <p data-bbox="156 1895 1513 2000">The practice told us following our site visit that it had also reviewed patients prescribed Methotrexate (a type of immunosuppressant used to slow down the body's immune system, help reduce inflammation and is used to treat inflammatory conditions including rheumatoid arthritis,</p>	

Medicines management	Y/N/Partial
<p>psoriasis and Crohn's disease). We did not review this category of patients during our clinical searches.</p> <ul style="list-style-type: none"> • We found that medication reviews were not always completed in appropriate detail. In particular, reviews did not always document if monitoring was up to date or requested and that any relevant safety information or advice had been provided. • We found that emergency medicines on site were organised, in date and effectively managed. We saw evidence of emergency medicines stock being checked routinely. 	

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:	6
Number of events that required action:	6
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> We found that the practice had an up to date significant and learning events policy and process and had recorded significant events centrally in a spreadsheet (the practice now used a web-based platform where significant events were now recorded) which set out a synopsis of the incident, why the incident had happened, what could have been done better, what the learning points were, what changes were agreed and when changes were to be completed. We saw evidence that significant events were discussed at the management meeting and the practice told us that learning outcomes would be shared with the team in the appropriate staff meetings, where significant events was a standing agenda item. Management meetings at the practice were held twice a week, clinical meetings were held monthly, reception meetings were held weekly and partner meetings were usually held every week. The practice told us that it reviewed all significant events to analyse whether any patterns were emerging. The practice told us that it had an open culture and encouraged staff members to report any incidents that were detected. Staff members we spoke with were able to explain how they would escalate incidents to management. 	

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

Event	Specific action taken
Sharps injury involving a member of staff	The practice identified that the practice protocol on sharps bin management had not been followed. The incident was reported immediately and the matter was discussed with the member of staff. The staff member was reminded of policy and protocol. The incident was discussed in all team meetings.
Repeat medication error	The practice identified that a patient had been issued with a prescription that had previously been stopped three years earlier when they had requested their other repeat medicines. The stopped medicine had remained on the repeat master list and the doctor had updated and issued all items. The practice reviewed the incident and identified as learning outcomes that

	all ceased repeat medicines should be removed from repeat master lists and that clinicians should carefully check all medicines and care records when performing medication reviews.
--	--

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We found that the system for managing and acting on Medicines and Healthcare Products Regulatory Agency (MHRA) alerts was not always effective. In particular, we found that an alert relating to Fournier's gangrene (an acute necrotic infection of the scrotum, penis or perineum) associated with Sodium-glucose co-transporter-2 (SGLT-2) inhibitors (oral medicines used to treat type two diabetes in adults) had not been actioned appropriately. We reviewed five out of 140 patients prescribed SGLT-2 inhibitors and found that there was no documented evidence that these patients had been advised of the risk of Fournier's gangrene. <p>The practice told us following our site visit that it did not have a record of the alert relating to Fournier's gangrene associated with SGLT-2 inhibitors on the spreadsheet logging system that was in use at the time of the alert (February 2019). The practice told us that it had since informed all 140 patients of the risk of Fournier's gangrene via text message.</p> <p>We identified that ten patients were on the combination of Omeprazole (a medicine used to treat indigestion, heartburn and acid reflux) and Clopidogrel (an anti-platelet medicine used to help prevent blood clots). The effect of the combination of these two medicines is that Omeprazole inhibits the effect of Clopidogrel and there is an increased risk of a cardiovascular event. The practice told us that it had reviewed all 10 patients since our site visit and that one patient had stopped Clopidogrel, two patients had not had any proton-pump inhibitor (PPI) medicines for several months (although it remained on their repeat lists) and the remaining patients had been informed and moved to another PPI medicine.</p> <p>We identified three patients who were prescribed Citalopram over 40mg or Escitalopram over 20mg (medicines that treats depression and panic attacks) who were over the age of 65. The effect of Citalopram over 40mg or Escitalopram over 20mg in over 65 year old patients was an increased risk of cardiac arrhythmia. The practice told us that it had reviewed all three patients since our site visit, had informed the patients and had reduced their dose.</p> <ul style="list-style-type: none"> The practice had a safety alerts policy and protocol and historically kept all MHRA alerts on a spreadsheet. The practice told us that it had changed its protocol from February 2022 and that all alerts were automatically received on the web-based platform that had been implemented. The system was set up so that the GP partner, practice manager and clinical pharmacist received an email when an alert was received, which acted as a failsafe. This was then reviewed by the clinical pharmacist and shared with the team if action was required. The practice told us that prior to February 2022, alerts were received via email which were then shared with the clinical pharmacist who would advise on further actions. The practice told us that all MHRA alerts were discussed at the relevant team meeting and the alerts module on the web-based platform was reviewed weekly in the management team meeting as a standing agenda item. 	

- The practice had recently started to use a web-based platform where alerts were now being logged, which was accessible to all staff.

Effective

Rating: Requires improvement

At this inspection, we rated the practice as requires improvement for providing effective services because:

- We identified some issues with the monitoring and management of long-term conditions, in particular in relation to patients with hypothyroidism.
- The practice had not met the minimum 90% uptake for four of the childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity).
- The practice's uptake for cervical screening was below the 80% coverage target for the national screening programme.

The practice was therefore rated as requires improvement for providing effective services.

Effective needs assessment, care and treatment

Patients' needs were 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.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• We found that the practice had a process for communicating guidance to keep clinicians up to date with current evidence-based guidelines. The practice told us that guidance was discussed in clinical meetings.• During the Covid-19 pandemic, the practice was proactive in its response and the healthcare assistant, nursing staff, social prescriber and GPs completed welfare checks on vulnerable patients.	

- The practice kept patients informed during the pandemic through use of remote meetings, which were regularly attended by 80 to 100 patients, and had provided updates to patients through a social media page and its website. The practice aimed to dispel antivaccine information and attempted to encourage patients to attend local Covid clinics, where the practice delivered additional sessions of vaccinations.

Effective care for the practice population

Findings

- The practice offered a range of general medical services which it delivered via a range of booked appointments with doctors, nursing team, and health care assistants. The practice offered home visits by doctors where appropriate. The practice offered a range of services and clinics for its population groups.
- The practice allocated all patients a named GP who was responsible for their overall care and coordinating services required. For patients aged over 75, the named GP would work with relevant associated health and social care professionals to deliver a multi-disciplinary package to meet the needs of the patients and ensured that patients had access to health checks.
- The practice had a lead for patients with learning disabilities and reviewed patients during the Covid-19 pandemic to ensure that all patients had adequate care. This involved calling patients and carers and calling patients in for face to face appointments. The practice telephoned patients and their carers and conducted some of the questions required during an appointment remotely, to limit the time spent of site.
- The practice recorded in clinical records where patients required adjustments, for example where patients had hearing impairments or mobility issues. The practice would provide longer appointments for patients where required.
- The practice ensured that patients were on the palliative care gold standard pathway and offered patients hospice outreach and home care as appropriate. The practice signposted to Macmillan cancer support where required.
- The practice assessed and monitored patients with poor mental health, including dementia and referred them to appropriate services.

Management of people with long term conditions

Findings

- We found that monitoring of patients with hypothyroidism had not always been completed appropriately within the specified timeframes. Our searches indicated 24 patients (out of a total of 589 patients with hypothyroidism) who had not had thyroid function monitoring in the last 18 months.

We reviewed four of these patients and found that the required monitoring had not been completed, although the practice had recognised that monitoring was due and had contacted the patients. Two of the patients had medication reviews coded but no details about the review had been recorded. Following our site visit, the practice told us that 96% of patients had been monitored within the specified timeframes. The practice informed us that it had sent reminders to all patients who required monitoring. It told us that some patients were under hospital care and it could not get the results, but had written to some, and that a few patients were abroad. The practice stated that it had reduced quantities of medicines to some patients to encourage compliance. The practice reported that some patients had been reluctant to attend for monitoring during the Covid-19 pandemic.

- We found that monitoring of patients with acute exacerbation of asthma was completed appropriately. We identified two patients who had previously been prescribed two or more courses of rescue steroids in the last 12 months who did not have a steroid card. The practice told us following our site visit that these two patients had now been sent steroid cards. We did not identify any issues with the over prescribing of Short-acting Beta Agonist (SABA) inhalers. Patients that had been prescribed over 12 inhalers in a 12 month period had been identified and sent a questionnaire to review medication, had received an asthma review or had been invited for an asthma review.
- We found that monitoring of patients with Chronic Kidney Disease stages four or five had been completed appropriately. We recommended that the practice could consider the documentation of results received from specialists in an accessible format on its clinical records system. The practice told us following our site visit that it was in the process of recruiting additional IT workflow personnel to improve the coding of results from hospital letters and instigate the transfer of coded data rather than textual letters in local communication flows.
- We found that monitoring of patients with diabetic retinopathy (a complication of diabetes, caused by high blood sugar levels damaging the back of the eye, the retina) who had a latest HbA1c of above 74 mmol/l was completed appropriately. We recommended that the practice could consider the documentation of results received from specialists in an accessible format on its clinical records system. We did not identify any issues with the missed diagnosis of diabetes.
- The practice told us that it regularly reviewed patients with long-term conditions and recalled patients by their month of birth. The practice would send patients a text message at the beginning of the month to advise them that a review was due and would contact patients who had not responded two weeks later. The practice reviewed long-term conditions lists fortnightly. The practice followed up on patients who had long-term conditions who had received treatment in secondary care by reviewing discharge summaries and following up on any further action required. The workflow team at the practice filtered out letters where doctor intervention was required and forwarded to the duty doctor to be actioned. A doctor at the practice audited the letters reviewed by the workflow team to ensure that quality was maintained. The practice held a diabetic clinic once a month with a diabetic specialist nurse for complex patients and the practice nurse conducted long-term condition reviews for asthma patients, with a doctor reviewing more complex patients.
- The practice proactively offered the diabetes prevention programme to patients and signposted to other organisations, such as diet and weight management classes, walking clubs and talking therapies.

- The practice told us that due to the national shortage of blood testing bottles in the summer of 2021 to early 2022, the performance of routine blood testing had been limited and impaired and that urgent testing had to be prioritised.

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)	195	213	91.5%	Met 90% minimum
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)	159	226	70.4%	Below 80% uptake
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)	174	226	77.0%	Below 80% uptake
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)	177	226	78.3%	Below 80% uptake
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)	23	33	69.7%	Below 80% uptake

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

Any additional evidence or comments

- The practice had not met the 90% uptake for four of the childhood immunisation uptake indicators (it met 90% in one of the indicators) and was below 80% in these indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all of the childhood indicators.

- The practice was working to improve the uptake of childhood immunisations and had a childhood immunisations protocol and a named vaccinations lead. The practice told us that during the Covid-19 pandemic, it had continued to provide access for childhood immunisations. In March 2022, it had reviewed and updated the way in which it recalled patients for vaccinations. The practice would coordinate immunisations with the post-natal eight week check so that patients would not need to reattend the practice for immunisations. The practice workflow team booked patients for an eight week appointment following notification of birth. The nurse would book 12 and 16 week immunisations at the previous visit. The practice would book 12 to 13 month and three years and four months to five years immunisations using searches run every two weeks. The nursing team would follow up patients who did not attend by text messages and telephone calls. The practice updated clinical records for patients who did not attend and offered opportunistically when parents or guardians attended the practice. The practice told us that it would refer patients who did not attend to the health visiting team and school nursing services for follow up where appropriate, with the safeguarding lead reviewing cases on an individual basis. The practice reviewed childhood immunisations monthly at practice meetings.
- The nurse we spoke with told us that they would contact parents and guardians who were concerned about childhood immunisations and would explain the process to encourage attendance. The practice told us that it had a cohort of patients who were Eastern European and were transient. The practice would contact these patients and speak with them using translation to explain to them the childhood immunisations process.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	67.4%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	59.6%	49.0%	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)	63.1%	57.1%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	60.0%	55.9%	55.4%	No statistical variation

Any additional evidence or comments

- The practice had a cervical screening policy and protocol and a responsible lead partner and responsible lead nurse who oversaw the running of the programme. The practice had a cervical screening call and recall protocol which detailed the failsafe processes at the practice.
- The practice was working to improve cervical screening uptake. The practice offered cervical screening opportunistically when patients attended appointments (with reminders set in clinical records) and conducted regular searches. The practice sent reminder letters to patients and telephoned patients to encourage their attendance. The practice told us that during the Covid-19 pandemic, some patients were reluctant to attend the practice for cervical screening. The practice informed us that some patients in its population group were reluctant to attend for religious or cultural reasons without speaking with their spouse. The practice nurse would call patients and spouses, where appropriate, and explain the cervical screening process to them and use translation services where required.
- The practice ran monthly searches to ensure that results from cervical screening had been received. The practice had searches set up on its clinical systems to detect patients who had not had cervical screening, to follow up on outstanding results, patients due cervical screening and patients with abnormal results who had defaulted. The cancer safety netting system detected patients who had not received a clinic appointment and the practice administrator would contact the patient to check whether an appointment had been received and liaise with the appropriate secondary services and clinician involved. The practice conducted a bi-annual cervical screening audit and discussed the results at its clinical meetings.

Monitoring care and treatment

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

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

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

Any additional evidence or comments

- Intrauterine device (IUD) audit 2020

The audit evaluated IUD fitting between 14 January 2020 to 15 January 2021 for retention and complication rates including perforation rate, pregnancy and expulsion.

The audit noted that the retention rate was 43 out of 56 over five years, there were no infections, the expulsion rate was 5%, there were no pregnancies and there were no perforations, which was consistent with national figures.

We also saw an IUD audit from 2019 to 2020.

- IUD audit 2022

The audit reviewed all IUDs fitted between June 2020 and 11 August 2022 to check for removals, expulsions and complications such as pregnancy or infection.

The audit noted a slightly higher expulsion rate (7%) than the previous audit and the practice stated that it would monitor this rate. The practice reported a retention rate of 78% and no pregnancies or infections. The practice stated that it would conduct the audit again in six months to review.

- Safeguarding review audit 2020 to 2021

The audit was conducted to review the accuracy of current safeguarding and vulnerable children recording and searches following the GP safeguarding lead for the area recommending that the practice update its lists of vulnerable patients and make contact during the Covid-19 lockdown.

The audit noted that due to the drop off in visits from liaison health visitors, the practices lists of at risk children were out of date and the practice did not always get updated information about safeguarding decisions, although all updated were logged and notes reviewed when correspondence was received. The practice assessed the accuracy of safeguarding information and developed strategies to improve accuracy so that vulnerable children could be supported during the pandemic and beyond.

The audit noted that lists were updated following the comparisons performed and that searches were to be completed regularly with coding to ensure that lists were kept up to date.

- Cancer audit 2022

The audit was an ongoing piece of work looking at cancer diagnosis figures compared to the local and national figures. The audit reviewed the total two week wait referrals and total new cancers for 2020, 2021 and 2022, including a breakdown of the type of cancers diagnosed. The practice stated that over the next 12 months it would review how and when cancers were diagnosed and whether it was referred patients early enough by the two week wait process or whether cancers were diagnosed late through acute presentation in A&E or other routes. The practice forwarded us the cancer diagnosis template used to collect data. The practice told us that the workflow team coded when a diagnosis of cancer was received and a GP partner reviewed all new diagnoses.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice encouraged staff to undertake training. Staff members told us that they were given protected time for training. The practice manager had oversight of staff training and assigned training modules using the new web-based platform for staff to complete and followed this up to ensure that training was up to date. The practice conducted annual appraisals with staff and identified development needs during this process. The practice told us that during the last year, due to the pressures from the Covid-19 pandemic and staff absences, the appraisals had been delayed. The practice ensured that staff members could contact the practice manager during this time with personal and professional issues. The practice supported staff in developing their skills and areas of interest. The practice gave an example of where feedback from a member of reception staff had led to a staff training plan being set up to allow staff time to complete learning disability training. The practice told us that it was in the process of transferring staff training records to the web-based platform it had put in place from February 2022. The practice told us that it had found recruitment and retention of staff to be a challenge, for both clinical and non-clinical staff due to the Covid-19 pandemic and the current climate. The practice had vacancies for GPs, a practice nurse, a member of the workflow team and reception staff, and was actively recruiting to these posts. The practice had some vacancies for partners after one partner had retired and one had relocated, which it hoped to fill in the future. The practice had devised a resilience plan to ensure that it had appropriate levels of staffing and had engaged with other practices in the PCN, who were also experiencing similar issues with recruitment. 	

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

Explanation of any answers and additional evidence:

- The practice acted on communications from external services to maintain continuity of care.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice utilised the services of two Primary Care Network (PCN) based social prescribed and referred patients for assistance with signposting to other services. The practice told us that it tried to get patients to play an active part in their care and spent time explaining to patients what was available to them and how and when to access services. The practice referred patients to a health and wellbeing coach through the PCN. 	

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.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• There was a process in place for DNACPR decisions, which were well documented in the clinical records system.	

Responsive

Rating: Unrated

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/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	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

Well-led

Rating: Requires improvement

At this inspection, we rated the practice as requires improvement for providing well-led services because:

- The practice was not always managing prescribing and associated monitoring in line with guidelines.
- The practice was not always appropriately managing patients with long-term conditions.
- The practice did not always maintain an accurate record in respect of each patient. Medication reviews were not always completed in detail, including that monitoring was up to date or requested and that any relevant safety information or advice had been addressed.
- The practice system for managing and acting on Medicines and Healthcare Products Regulatory Agency alerts was not always effective.

Therefore we have rated the practice as requires improvement for providing well-led services.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had worked on succession planning and the lead GP partner was considering retiring in the near future. The practice told us that the GP partner had handed over some of the governance responsibilities, which would be continued. The practice stated that they would need to recruit two or three new partners, and hoped that salaried doctors would fill these posts.	

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 vision statement which detailed that its mission was to provide a modern, responsive and efficient service tailored to patients' individual needs, putting patients at the centre of their care and working in partnership. The practice told us that they cared about patients and that it wanted patients to have good access and standards of healthcare. The practice informed us that it had designed the service to meet patient needs and that it listened to patients and adapted systems to make improvements.
- Staff we spoke with were fully conversant with the values and evidenced their understanding and role in achieving this.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice provided support to staff during the Covid-19 pandemic. It conducted workplace safety risk assessments and identified adjustments where appropriate. The practice also conducted data protection risk assessments, display screen equipment assessments and homeworking assessments for staff members. The practice had a staff suggestion box in the staff room and encouraged staff to give feedback on changes to standard operating procedures, policies and protocols. The practice told us that during the Covid-19 pandemic, it had sought the views of staff on the standard operating procedure to help people feel safe at work. It had put in place screens on the reception area, which remained in place. The practice had involved staff and encouraged feedback to the use of the new system of online consultation. The practice told us that when changes were made, these were discussed with staff members in team meetings and staff we asked to give feedback or report their concerns. • We received feedback in staff interviews that suggested that there was a positive relationship between staff and management, with staff reporting that they enjoyed working at the practice. 	

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

Source	Feedback
Staff interviews	All staff we interview spoke positively about their employment at the practice. Staff members stated that they felt managers and clinicians were supportive and they felt comfortable and confident in raising issues with them.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice had a governance framework, however, it was not always effectively managing risks. These included the risks associated with the required monitoring of patients on high-risk medicines, actioning of patient safety alerts and management of long-term conditions. 	

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance, however some improvements were required.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> We found that the practice was not always keeping accurate or comprehensive clinical records. In particular, medication reviews were not always completed in detail in the medical records, including not displaying that all monitoring was up to date or requested and that any relevant safety information or advice had been addressed. The practice had a prescribing high risk 	

medication policy and repeat prescribing policy however we did not see evidence that this was always followed in the patients we reviewed.

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y

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: <ul style="list-style-type: none"> The practice had worked to develop a digital front door to make systems smoother and had a dedicated workflow team to assist with this aim. The practice was working alongside the PCN and participating in making improvements. The practice acted on feedback received from patients about econsult and was a champion practice for the roll out of the new online consultation system, which was more user friendly for patients. 	

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had historically held regularly quarterly Patient Participation Group (PPG) meetings and engaged outside speakers, including the dementia group and immunisation lead. During the Covid-19 pandemic, the practice held PPG meetings remotely. The practice told us that it had lost some of its members during the pandemic and was currently trying to recruit new members, which was part of the practice's recovery plan for 2022 to 2023. The practice updated members during the meetings, for example, the practice had spoken with members about the new electronic consultation system. 	

Feedback from Patient Participation Group.

Feedback

We spoke with a member of the PPG who told us that they had attended online meetings and that they were attended by the lead GP partner. They told us that the attendees were given an opportunity to ask questions and that each question was answered or that a response was provided by email after the meeting. The PPG member stated that the practice was open and honest.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Staff at the practice were encouraged and supported to undertake learning. Staff members told us that management was supportive of their development needs and aspirations. The practice was supporting a former member of the workflow team to move into a HCA role and through their Care Certificate training. The practice had a culture of sharing learning from significant events and complaints and made improvements as a result of lessons learned. 	

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.