

# Care Quality Commission

## Inspection Evidence Table

### Barking Medical Group Practice (1-546149998)

Inspection date: remote interviews 7 & 8 March 2022, onsite visit 9 March 2022, remote clinical records review 11 March 2022.

Date of data download: 21 February 2022

## Overall rating: Requires Improvement

The practice is rated as requires improvement overall as there was a lack of effective governance to ensure that comprehensive safety and risk management processes were in place. Reviews of clinical records did not indicate that care consistently met patient needs and not all required training had been completed. GP patient survey feedback about treatment by staff and access was below local and national averages and other sources of feedback indicated problems with the practices systems for access. However, we did find that staff felt well supported and respected and that the practice had responsive to the health needs of the most vulnerable patients during the pandemic. We also found a commitment to learning and improvement and that plans were in place to respond to the health needs of the practice's demographics.

## Safe

## Rating: Inadequate

Systems related to safeguarding, recruitment, premises and the management of medicines were not sufficiently comprehensive to ensure that risks were identified and acted upon.

### Safety systems and processes

**The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.**

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial 1
Partners and staff were trained to appropriate levels for their role.	N 2
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	N
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	N

Safeguarding	Y/N/Partial
<p>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.</p>	<p>Y</p>
<p>1. One staff member we spoke with was not aware of the requirements for coding and reporting cases of suspected female genital mutilation (FGM).</p> <p>The practice's locum pack contained contradictory information about safeguarding leads within the local authority.</p> <p>2. The files of non-clinical staff we reviewed showed that nonclinical staff had completed level 1 child safeguarding training and not level 2 as outlined in the most recent intercollegiate guidance or the practice's child and adult safeguarding policy. The practice manager confirmed that nonclinical staff were trained to level 1. It was unclear the last time the locum nurse working at the practice had completed level 3 safeguarding training. Updated training was provided for this staff member after our inspection.</p> <p>3. There was no system in place to inform the local out of hours service of relevant safeguarding information.</p> <p>4. The practice's recruitment policy stated that:</p> <p><i>Clinical roles or those that otherwise involve contact with patients will usually require a DBS check before the successful candidate starts in the position.</i></p> <p>We checked the receptionist's recruitment file on the day of inspection and there was no DBS in their file. This staff member was not working at the practice at the time of our inspection and we were told that a check would be completed on the staff member's return.</p>	

Recruitment systems	Y/N/Partial
<p>Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).</p>	<p>Partial 1</p>
<p>Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.</p>	<p>N 2</p>
<p>1. One staff member had personal but no employment references. There were gaps in employment in the CVs/applications of two staff members but there was no evidence that this had been considered or investigated by the practice prior to the staff member starting work.</p> <p>There was no record of checks on medical indemnity insurance for a locum nurse. Confirmation of indemnity was provided after inspection.</p>	

The newly appointed practice manager provided us with a template to use in future for recruitment which would support staff in ensuring that all appropriate checks were completed and that documentation was then appropriately organised and stored.

2. The practice did not obtain confirmation of the vaccination status for non-clinical staff and cleaning staff and there was no risk assessment present to consider the need for vaccination of these staff.

Safety systems and records	Y/N/Partial
<p>Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Orchards Surgery 24/2/2022 Upney Lane: 01/3/2022</p> <p>Legionella risk assessment  Orchards surgery: 27/01/2020 Upney Lane: 29/10/2015</p>	<p>Partial 1</p>
<p>There was a fire procedure.</p>	<p>Y</p>
<p>Date of fire risk assessment: Orchard's Health Centre 11/11/2021 Upney Lane: no risk assessment</p> <p>Actions from fire risk assessment were identified and completed.</p>	<p>Partial 2</p>
<p>1. Both health and safety risk assessments completed for each site highlighted low level risks. The risk assessment form stated that:</p> <p><i>“Where the perceived risk is low, the Practice may decide that action is unnecessary at this time; however, this should be documented, and that area kept under regular review.”</i></p> <p>There was no supporting documentation to show that the practice had considered the risk identified and made a decision that action was unnecessary. However, when we raised this with the practice manager during our site visit, the practice manager documented the action that would be taken on the risk assessment.</p> <p>One of the site's legionella risk assessments had last been completed in 2015. In the cases of both legionella risk assessments there were action points to be completed but it was not clear from the documentation that these had been completed. The practice provided evidence of temperature checks, though it was unclear which site these related to, for 2021 and 2022 and on occasion this showed that hot water temperatures were not sufficiently high (over 55 degrees Celsius) to mitigate the risks of legionella in a healthcare setting. The practice told us that a further risk assessment was completed after our inspection.</p>	

- There was no fire risk assessment completed for Upney Lane Medical Centre. The provider had completed a general risk assessment for Upney Lane which referred to the presence of a fireproof safe and a fire extinguisher. We were told that a fire risk assessment had been booked for this site after our inspection.

The practice had only one Control of Substances hazardous to Health (COSHH) risk assessment for bleach. The practice provided an up to date COSHH assessment the day of our inspection and the infection control lead and other staff members undertook COSHH training after our visit.

Portable appliance testing and equipment calibration had not been completed since July 2020 which was valid for a single year. The practice Told us that this was completed after our inspection

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial 1
Infection prevention and control audits were carried out. Date of last infection prevention and control audit:  Orchard 02/2/2022 Upney Lane 11/03/2021	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
1. The staff member who acted as lead for infection prevention control did not have specific training for this role.	

## Risks to patients

### There were gaps in 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.	N 1
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial 2
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
<p>1. One of the clinical staff whose files we reviewed had no induction on record.</p> <p>2. The practice provided printouts showing the members of staff who had completed sepsis training. The practice nurse was not listed as having completed this training.</p> <p>The practice's staff training matrix indicated that seven members of non-clinical staff had either not completed basic life support training or had expired training. We reviewed the file of two of these staff members and found that one had training which had expired, and one had not completed this training. Completed training was provided after our inspection for one staff member and the other was currently on long term leave.</p>	

### 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

### Appropriate and safe use of medicines

**The practice systems for the appropriate and safe use of medicines need to be improved.**

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR	0.62	0.54	0.71	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
PU) (01/10/2020 to 30/09/2021) (NHS Business Service Authority - NHSBSA)				
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). (01/10/2020 to 30/09/2021) (NHSBSA)	6.4%	10.6%	9.8%	Tending towards variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2021 to 30/09/2021) (NHSBSA)	6.67	5.90	5.32	Tending towards variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2021 to 30/09/2021) (NHSBSA)	64.2‰	64.5‰	128.1‰	Tending towards variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2020 to 30/09/2021) (NHSBSA)	0.35	0.50	0.63	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2021 to 30/09/2021) (NHSBSA)	5.4‰	5.5‰	6.7‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Partial 1
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 2
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 2

Medicines management	Y/N/Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Not checked
There were arrangements for raising concerns around controlled drugs with the NHS England 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.	Partial 3
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.	Partial 4
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 PHE guidance to ensure they remained safe and effective.	Partial 5
<p>1. Although the practice was able to demonstrate that non-medical prescribers were competent to undertake their role; there were no documented reviews, checks or audits of their prescribing to ensure that this was safe and appropriate. However, the non-medical prescribers we spoke with described being well supported and able to ask questions to GPs whenever needed.</p> <p>2. We ran searches of patients prescribed high risk medicines and medicines that required regular monitoring. We look at five patients prescribed ACE inhibitor or Angiotensin II. Four patients were overdue U &amp; E monitoring and one had none on record. Medication reviews were overdue for all patients and the practice had not done these for two patients despite them attending for face to face appointments.</p> <p>3. The practice told us that a possible cause for the increase in prescribing of certain classes of antibiotics for uncomplicated urinary tract infections (UTI) could have been caused by patients not being diagnosed using urine dipstick testing during the period between April and September 2021 due to the lockdowns during covid 19 and were being diagnosed on the basis of the description of symptoms alone. The practice told us that they would raise this in a clinical meeting; asking GPs to encourage patients to attend for dipstick testing prior to prescribing antibiotics for UTIs.</p> <p>4. We looked at the practice's stock of emergency medicines at the Upney Lane site and found that the following recommended medicines were not available:</p> <p>Dexamethasone Diclofenac Midazolam Naloxone Opiates</p> <p>There was no risk assessment present to explain the absence of these medicines. However, a brief risk assessment for the missing medicines was drafted and provided to inspection staff during the</p>	

Medicines management	Y/N/Partial
<p>site visit although this only indicated in most instances that the practice should assist the patient and then call 999.</p> <p>We also found that a packet of aspirin which expired in February 2022, although another packet was available, and that the stock of Furosemide had expired in April 2021. The practice undertook a significant event analysis in response to this being highlighted by inspectors and updated their protocol for checking emergency medicines.</p>	
<p>5. We found a blank audit template attached to the cold chain policy and ask the practice to ensure this is completed, the practice manager completed the audit during our site visit.</p>	

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

**The practice learned and made improvements when things went wrong. However, we saw minutes from a meeting which suggested staff may have been deterred from raising concerns.**

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Partial 1
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:	7
Number of events that required action:	7

1. We saw reference in the practice's summary of complaint spreadsheet that a complaint from September 2021 had been identified as needing to be treated as a significant event. There was nothing in the practice's significant event spreadsheet which indicated that this complaint had been dealt with under the practice's procedure.

The practice's significant event policy stated that the purpose of significant event analysis was to:

*To detect any preventable causes and examine them carefully, from different perspectives, without attaching blame.*

However, we reviewed the minutes of a meeting held on August 2021 which stated that:

*Significant event could now lead to disciplinary action if problems keep occurring. After completing 2 SEA, staff will get a warning letter, which will stay on their record for 12 months, 2nd warning letter in the same year will initiate a disciplinary process.*



Linking the disciplinary process to significant event reporting could result in staff being discouraged from reporting significant events. However, all staff we spoke with said that they would be happy to raise concerns or mistakes that could amount to a significant event.

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Request for urgent medicine added to non-urgent scanning pile which resulted in a delay with treatment	No patient harm. Staff reminded on procedure for how to identify and escalate urgent prescriptions to the GPs
Patient prescribed additional dose of medication without adjusting existing store of medication	Patient checked by clinician and informed of error. Staff urged to be vigilant and check existing medication before adjusting doses.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Partial 1
1. We undertook a search of patients prescribed omeprazole and clopidogrel. These medicines should not be prescribed together as (omeprazole has been found to impact the antiplatelet effect of clopidogrel). This alert was issued in 2014. We reviewed five of the patients identified by the search. All patients had been issued prescriptions for this combination of medicines between January 2022 and March 2022. One patient had received no contact about this risk associated with this medicine and the other four patients had been contacted on either 28 February 2022 or 1 March 2022 to inform them of the risk associated with taking these medicines together.	

## Effective

## Rating: Requires Improvement

The practice had undertaken several quality improvement projects that resulted in improvements in patient care and treatment and were proactively reaching out to patients and tailoring services in response to both patient and changes and limitations within the local healthcare economy. However, reviews of records did not indicate that clinical guidelines and requirements were being consistently adhered to. We also found that mandatory training had not been completed by all staff. The practice was also below target for childhood immunisations and cervical screening; though the practice outlined action taken to improve uptake of immunisations and submitted unverified data which suggested that cervical screening rates had improved.

### Effective needs assessment, care and treatment

**Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools. However we found some issues with coding of patient records, action taken in response to safety alerts and clinical assessments**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Partial 1
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial 2
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	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
1 & 2 From the small sample of records reviewed as part of our clinical assessment we found that patient safety alerts were not being acted upon in a timely way which meant that the practice was not following current evidence based practice. Reviews of records for those with long term conditions indicated that weaknesses in some systems prevented correct and full assessment for some patients. This is detailed below in the "Management of people with long term conditions" section below.	

### Effective care for the practice population

## Findings

- The practice provided care and support to several patients at local care and residential homes. We contacted all these services and were able to speak with staff at one who told us that during the pandemic the practice maintained care using video consultations. Generally, were told that the practice would provide same day access to a GP for vulnerable residents.
- Health checks were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- 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 considered the needs of those whose circumstances may make them vulnerable. The practice told us that during the pandemic they would do video calls for every patient on their palliative care register once a month. For those living alone with no access to technology that facilitated video calls, the practice asked for visits to be undertaken by a district nurse. The practice told us that for two patients, the practice's registrar performed check ins by standing outside the patient's house and speaking with them through the window.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

- We ran a search of patients who had diagnostic results recorded that indicated that they were pre diabetic. We reviewed five of these records and identified concerns with four including; patients not being coded as diabetic; patients only being coded in February 2022 despite testing indicating that they had been pre diabetic for several years and a lack of action being taken in response to prediabetic readings.
- We ran a search of patients prescribed 12 or more saba inhalers over a 12-month period. We reviewed three of those records flagged by the search and found that asthma reviews had been done for two of these patients and that one patient was not coded as being asthmatic and had no diagnosis of asthma recorded despite having had 12 inhalers issued. We also ran a search of patients with asthma who had been prescribed two or more courses of steroids in the last 12 months. Four of these records did not contain adequate assessment of the patient prior to issuing steroids and the other contained no assessment.
- The practice told us that they had trained healthcare assistants to undertake phlebotomy during the pandemic as blood testing services became stretched. This enabled the practice to continue to monitor patients on medications and complete checks for those diagnosed with diabetes and monitoring for other long term conditions that was impacted by the pandemic. The practice had 900

patients with diabetes and told us that management of these patient had been challenged by blood bottle shortages and other difficulties associated with the pandemic.

- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered blood pressure monitoring.
- Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	139	144	96.5%	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) (01/04/2019 to 31/03/2020) (NHS England)	133	161	82.6%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	134	161	83.2%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	132	161	82.0%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	163	194	84.0%	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

The practice told us that their population contained above average rates of social deprivation and health inequalities which created challenges in achieving childhood immunisation targets and that conditions created by the covid 19 pandemic (people isolating or infected and the shift in primary care's focus to delivery of covid 19 vaccines) adversely impacted the practice's ability to meet these targets.

We were told that below target uptake for childhood immunisations was a continual focus for the Clinical Commissioning Group (CCG) and Primary Care Network (PCN). The practice themselves told us of action they had taken to try and encourage uptake including having dedicated appointment slots for childhood immunisations at their Saturday surgeries and signposting patients who may object to vaccination on religious grounds to the websites of religious organisations who have debunked inaccuracies about the content of vaccines.

Cancer Indicators	Practice	CCG average	England average	England comparison
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). (Snapshot date: 30/06/2021) (Public Health England)	69.8%	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) (PHE)	65.1%	54.8%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (PHE)	60.0%	58.1%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (PHE)	56.3%	53.2%	55.4%	No statistical variation

#### Any additional evidence or comments

The practice had completed a review of cervical screenings completed in 2021/2022 to ensure that those who required onward referrals had been completed where required and that subsequent cervical screenings were scheduled at the appropriate interval.

The practice told us that from a recent search of their clinical systems they had achieved 81% uptake for cervical screening for those in the 25 – 49 age group and 83% in the 50 – 64 age group and hoped to improve on this further with the introduction of more nursing appointments.

The practice could direct patients to a local hub service run by the PCN or offer an appointment during their own extended hours for patients wanting to have screening outside of working hours.

## 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.	Not checked

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

The practice had completed a two cycle audit of patients prescribed a medicine to treat osteoporosis. Guidelines recommend that patients should have their treatment reviewed every five years. The practice ran a search of their clinical system to identify patients who had been taking this medication for over five years without a review and those who had been taking it for over 10 years. For those taking the medication for over 10 years patients would be offered a medication break and assessment would be undertaken to see if other support could be offered. The audit also aimed to ensure all those who had not been reviewed had a review completed, that vitamin D and calcium monitoring had been undertaken and to provide education to patients on the risks of this medicine. Between the first and second cycle of the audit the number of patients on this medicine for over five years without a review reduced from 17 to 12 and the number of patients on this medication over 10 years without a review reduced from 11 to one. Furthermore, the number of patients who had vitamin D and calcium monitoring increased from 22 patients to 41 patients between the first and second cycle.

The practice had completed a two-cycle audit of patients prescribed direct oral anti-coagulant medicines (DOACs) which aimed to improve the proportion of patients who were prescribed the correct dose of medicine and had the required monitoring completed. At the second cycle 68% of patients had their renal function tested within the recommended time period, an increase from 41% in the first cycle, and 76% of patients had their weight measurement done within the recommended time frame, an increase from 35% in the first cycle. Additionally, 76% of patients had both a weight measurement and blood test done within the last year, an increase from 22% from the first cycle.

The practice had initiated a quality improvement project aimed at reviewing the practice's child safeguarding processes.

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Partial 1
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.	Partial 2
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial 3
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<ol style="list-style-type: none"> <li>1. Not all mandatory training had been completed by all staff whose files we reviewed or some of the training had expired. Nonclinical staff had not completed the correct level of safeguarding training. We found that of the five staff members whose files there were gaps in basic life support, fire safety and information governance training and that the practice nurse had not completed mental capacity act training. Some of this training was completed following our inspection.</li> <li>2. Some appraisals lacked sufficient detail to make them effective. Staff outlined several areas where they felt that they would benefit from additional training and all said that they had fed this back to their line manager who was supportive or had arranged for the suggested training to be completed.</li> <li>3. Although the practice was able to demonstrate that non-medical prescribers were competent to undertake their role; there were no documented reviews, checks or audits of their prescribing to ensure that this was safe and appropriate. However, the non-medical prescribers we spoke with described being well supported and able to ask questions to GPs whenever needed.</li> </ol>	

## 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-centered care when they moved between services.	Y
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### Helping patients to live healthier lives

#### Staff were not always 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.	Partial 1
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
1. While the practice outlined how they supported patients in the last 12 months of their lives and had adjusted their approach to ensure that these patients were monitored and supported, reviews of clinical records of people whose blood sugar test results suggested a possible diagnosis of diabetes indicated that systems to respond to those at risk of developing a long term condition needed improvement.	

#### Any additional evidence or comments

### Consent to care and treatment

#### The practice had systems to obtain consent to care and treatment and staff were aware of the legislation and guidance related to consent.

	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



## Caring

## Rating: Requires Improvement

National GP patient survey scores related to staff at the practice treating patients with care and concern were below local and national averages. The practice had not undertaken any specific action in response to this feedback. However, changes had been made to the service's access model in the hope that this would improve patient satisfaction generally. Feedback from the practice's own friends and family test suggested that patient satisfaction overall had improved after these changes were made.

### Kindness, respect and compassion

**Staff told us that they treated patients with kindness, respect and compassion. Feedback from patients was mixed about the way staff treated people.**

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

Patient feedback	
Source	Feedback
Friends and family test	See below
Feedback to CQC	CQC received feedback from patients. This primarily related to issues around access and the attitude of reception staff. The volume of negative feedback had decreased from the time the practice told us that they had made changes to the system for access.
Google reviews	78 reviews left with a two star rating overall. Most of the feedback related to issues with access and the approach and tone of the reception team.
NHS Choices	Nine reviews. Seven one star reviews, one two star review and one five star review. Concerns raised in the reviews relate mostly to the appointment system and the service provided by the practice reception team.

### National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	79.9%	85.0%	89.4%	Tending towards variation (negative)

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)	71.9%	82.8%	88.4%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	89.6%	92.8%	95.6%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	76.2%	77.0%	83.0%	No statistical variation

#### Any additional evidence or comments

When we asked the practice about the score that were below local and national averages they said that they took this on board and will make efforts to improve this by discussing more patient encounters and complaints in clinical meetings so that they could learn from their mistakes and try to make the patient experience better.

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

#### Any additional evidence

The practice participated in friends and family test. Between April 2021 and March 2022, the practice had received 290 responses. Of these responses 87% said that they were likely or extremely likely to recommend the service to friends or family, 9% said unlikely or extremely unlikely and the remainder said neither or that they did not know.

The survey provided comments from patients about the service received. The negative comments received primarily related to wait times when contacting the practice by telephone and the attitude of some members of the reception team. However, feedback appeared to improve after September 2021.

#### Involvement in decisions about care and treatment

**Staff helped patients to be involved in decisions about care and treatment.**

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y

Staff helped patients and their carers find further information and access community and advocacy services.	Y
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## National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	85.8%	88.8%	92.9%	Tending towards variation (negative)

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified.	2% 219
How the practice supported carers (including young carers).	There were leaflets in the reception area advertising local carer support organisations and staff could refer patients to a member of the reception team who acted as a carer's champion. This person could direct patients to local carer and other support services in the area. Previously the practice hosted a member of staff from a local carer support organisation and hoped that this would be reintroduced following the pandemic. We were told that during the pandemic the practice contacted all patients who cared for someone with dementia to ask if they needed support.
How the practice supported recently bereaved patients.	We were told that when the practice is notified of a death they will send a sympathy card to relatives and carers and encourage them to contact the practice if they need support. If bereavement was raised by a patient during a consultation, we were told that they would be directed to local bereavement counselling services.

## Privacy and dignity

**The practice respected patients' privacy and dignity.**

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

## Responsive

## Rating: Requires Improvement

The practice was aware of the health and social needs of their local population and had designed services to meet these. They also had systems in place to respond to complaints. However, patient feedback consistently highlighted concerns regarding access to appointments. Though the practice had taken action to address this, concerns were still highlighted in some of the feedback we reviewed regarding both the phone and online appointment system.

### Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Practice Opening Times	
Day	Time
Opening times:	
Monday	8:30 am – 8:00 pm
Tuesday	8:30 am - 6:30 pm
Wednesday	8:30 am - 6:30 pm
Thursday	8:30 am - 6:30 pm
Friday	8:30 am - 6:30 pm
Saturday	8:30 am - 1:00 pm

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> <li>The practice had identified that their practice demographics had a high prevalence of long term conditions including hypertension and diabetes. The practice was working to try and improve the monitoring of these patients as this had been impacted by the pandemic. For example, we were told that they were now completing the eight care processes for patients with diabetes and working with local GPs in the PCN who had specialist interest in diabetes. The practice healthcare assistant had also been trained as a phlebotomist so that they could assist with monitoring of these patients.</li> <li>Patients had a named GP who supported them in whatever setting they lived.</li> <li>The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.</li> </ul>

- The practice liaised with the community services to discuss and manage the needs of patients with complex medical issues.
- Late appointments were available until 8:30 pm on a Monday for school age children so that they did not need to miss school.
- All parents or guardians calling with concerns about a child under 5 were offered a same day appointment.
- The practice was open until 8.30pm on a Monday and between 8:30 am. Pre-bookable appointments were also available to all patients at a local hub.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice told us that they had 81 patients with a learning disability and 75 of those had received an annual health check.
- Patients with learning disabilities, those who had a first diagnosis of diabetes and patients who required a translator were given double appointments.

**Access to the service**

**People were not consistently 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 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	Partial
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Partial
Patients were able to make appointments in a way which met their needs	Partial
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
The practice identified problems with the access to their service, particularly difficulties patients faced trying to get through to the surgery on the telephone. In order to address this the practice had contacted their telephone provider to try and resolve the problem. When patients continued to complain about the telephone system, the practice got reception staff to ask patients how long they had been kept on hold and what difficulties they had contacting the practice. The practice then fed this back to the telephone provider who took further action to try and resolve the issue.	

Practice staff told us that they were proud to have kept the surgery open to patients throughout the pandemic and said they always had clinical staff available to offer face to face appointments during this period.

The practice told us that they had changed their system for routine appointment booking with most patients now being required to book these using an online system. Requests for routine appointments would be reviewed within 48 – 72 hours; we saw information from the clinical records to support this. Routine appointments could be requested up to four weeks in advance. We were told that this change was done in order to free up the phonelines for emergency appointment requests which could still be made over the phone. The practice had made this change to cater to working age people who the practice said made up the vast proportion of their patient demographic. We were told that the following categories of patient were still able to book routine appointments over the phone:

- Over age 75
- Palliative care patients
- Children under 5
- Poor Computer literacy and no access to a device
- Those with learning disabilities or Dyslexia
- Those with mental health concerns
- Other patients considered vulnerable

These patients would also be prioritised for emergency appointments.

The practice had employed a locum advanced nurse practitioner (ANP) to assist with triaging of patients, dealing with minor ailments and directing patients to pharmacy services.

## National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	56.8%	N/A	67.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	57.2%	65.8%	70.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice	55.4%	64.4%	67.0%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
appointment times (01/01/2021 to 31/03/2021)				
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	75.2%	76.3%	81.7%	No statistical variation

### Any additional evidence or comments

Patient feedback obtained from several sources indicated that a proportion of the practice population found it difficult to access appointments. Although the practice had made changes to their appointment system on the basis of these concerns and feedback from their friends and family test indicated that access was no longer as much of a concern as it was prior to this change; there was still negative feedback about the practice's booking system including the new online booking system which, some feedback indicated, was difficult to use and had not helped problems with access.

Source	Feedback
NHS Choices	9 reviews. Seven one star reviews, one two star review and one five star review. Concerns raised in the reviews relate mostly to the appointment system including the length of time to get through on the phone and difficulties using the online booking system.
Feedback to CQC	CQC received feedback from patients. Most of this related to access to appointments. However, this had reduced at the start of 2022.
Google Review	78 reviews left with a two star rating overall. Most of the feedback related to issues with access and the appointment system including the telephone and online booking systems.
Friends and family test	There was a larger volume of qualitative feedback about difficulties access appointments in early 2021 than there was in late 2021/early 2022.

### Listening and learning from concerns and complaints

**Complaints were listened and responded to and used to improve the quality of care.**

Complaints	
Number of complaints received in the last year.	23
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

Y/N/Partial



Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Examples of learning from complaints.

Complaint	Specific action taken
All complaints reviewed contained potentially identifiable information and therefore have not been reported on	

## Well-led

## Rating: Requires Improvement

Staff fed back positively about the leadership team and the support they provided. The practice was aware of the challenges they faced and had plans in place to address these. There was a focus on learning and development through helping staff to develop and supporting local medical students and trainees. However, we identified issues around governance and risk management that needed to be addressed.

### 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
The practice was aware of challenges facing the service including local health inequalities and pressures related to funding and workforce. The practice was undertaking work in collaboration with their PCN to improve the care provided to diabetic patients and had devised plans to address poor health outcomes resulting from obesity and mental health conditions.	

### Vision and strategy

**The practice had a clear vision and strategy to provide high quality care. However, lack of effective governance and risk management impeded the practice's ability to provide consistently safe and effective 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
<p>The practice had a mission to:</p> <ul style="list-style-type: none"> <li>• deliver the best possible clinical care from their team of doctors, nurses and allied medical professionals and a courteous, efficient and friendly service from our admin and reception team.</li> <li>• Work in partnership with patients and staff to provide the best Primary Care services possible working within local and national governance, guidance and regulations.</li> </ul> <p>However, deficiencies in governance and systems to manage risk needed to be addressed in order for the practice to achieve these aims.</p>	

To address increased demand and staffing shortages the practice had upskilled their healthcare assistant and had plans in place to provide them with further support to enable them to become a nurse practitioner.

## Culture

**Staff feedback indicated that 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.	Partial 1
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
1. Although staff said that they felt able to raise concerns without fear of retribution, we saw a meeting from August 2021 which linked the repeated reporting or identification of significant events to the disciplinary procedure.	

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

Source	Feedback
Staff feedback	Staff reported feeling well supported and valued by the leadership team. Staff told us that they were able to raise concerns or ask for additional training and development.

## Governance arrangements

**The overall governance arrangements needed to be reviewed and improved to ensure safe care and consistently effective treatment.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial 1
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Partial 2

1. Governance systems and processes did not operate effectively in several areas including the management of safety alerts and oversight of staff training.
2. There was no system to share safeguarding concerns with the local out of hours service.

## Managing risks, issues and performance

### The practice did not have clear and effective processes for managing areas of risk.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N 1
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.	N 1
A major incident plan was in place.	Partial 2
Staff were trained in preparation for major incidents.	Partial 3
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
1. There were several areas related to risk where systems did not operate effectively including the management of medicines and assessing and acting upon risks associated with the premises.	
2. The practice's business continuity plan did not contain all staff contact details. However, staff at the practice told us that they were all part of a text group chat which would enable staff to be contacted in the event of a major incident.	
3. Most nonclinical staff had not completed basic life support training.	

### 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 1
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
1. While patients could book emergency appointments using the telephone, the practice had decided that all routine appointments had to be requested using an online portal. The practice described the support in place to enable patients to register and use the online system. The practice told us that certain criteria of patients were still able to access routine appointments using the telephone including those over 75 and children under 5.	

### 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

### 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.	N/A
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

## 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; though there had only been a single meeting with the PPG since the start of the pandemic.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Partial 1
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>1 The practice told us that prior to the pandemic they would hold quarterly meetings with their Patient Participation Group (PPG). However, due to the pandemic, there had not been any meetings of the PPG in 2020. They told us that one meeting had been held remotely in 2021. We were told that the new practice manager was planning on holding more PPG meetings now that covid restrictions were starting to ease.</p> <p>The practice was attempting to increase the numbers of patients in their PPG by encouraging those joining the practice to become members and advertising the group on their website and in the reception area.</p> <p>The practice provided an example of change enacted on the basis of PPG feedback whereby they had asked for easy to read materials for those with dyslexia.</p>	

## 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
<p>The practice is a teaching practice supporting doctors both studying and registrars in training. One of the practice partners had been awarded best tutor (2019) and one of the reception staff best admin support (2021) which was voted on by trainees within the locality. Trainees providing care to patients or observation of appointments were done within a double slot to allow for a debriefing session with the doctor.</p>	

## Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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

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