

Care Quality Commission

Inspection Evidence Table

Bellevue Medical Practice (1-2584248499)

Inspection date: 25 August 2022

Date of data download: 23 August 2022

Overall rating: Requires Improvement

We have rated the practice as requires improvement overall as we identified concerns in the management of patients on high risk medicines and those patients with long term conditions. The practice continued to achieve below the national uptake targets for childrens immunisations and cervical cancer screening.

Safe

Rating: Requires Improvement

We have rated the practice as requires improvement for providing safe services as we identified concerns in the management of patients' medicines and found some patients had not received regular monitoring of their health conditions.

Safety systems and processes

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

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

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> The practice demonstrated an effective and thorough process of ensuring safeguarding was a key part of patient care. Staff demonstrated clear awareness of their responsibilities around reporting incidents if they suspected a concern. The practice had policies and processes to support staff in this area and staff were clear on how they accessed these policies. Staff had completed safeguarding training relevant to their role. Staff files reviewed demonstrated that Disclosure and Barring Service (DBS) checks were in place for staff as part of pre employment checks. This included enhanced and standard DBS checks based on the role and responsibilities of the job. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. A random sample of records viewed during the inspection confirmed they had effective safeguarding registers in place that were monitored regularly. Evidence provided showed regular multi-disciplinary meetings were held to discuss patients with safeguarding concerns. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice was part of a larger organisation and had a centralised human resources team in place. We looked at a sample of recruitment files and found the appropriate recruitment checks were in place prior to employment. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: June 2022	Y
There was a fire procedure. Date of fire risk assessment: September 2021	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There was a Health and Safety policy in place and risk assessments had been carried out at the practice. A fire risk assessment had been completed and an action plan was in place. Evidence provided showed identified risks had been acted on. For example: During the risk assessment it was noted that the hinges to several fire doors had deteriorated almost to the point of failure. The practice had replaced all the relevant hinges. Training records showed fire safety training had been completed by all staff. 	

- Evidence provided by the practice showed equipment was regularly calibrated and electrical items were tested .
- Control of Substances Hazardous to Health (COSHH) risk assessments and safety information was in place.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit:	
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice had an infection control policy in place and a range of audits to monitor infection control arrangements were being adhered too. However, we found curtains in consultation rooms had not been changed in line with recommended guidance of curtains being replaced every six months, the curtains we checked had last been changed in October 2021. • During our site visit we found the premises visually clean and tidy and that staff had access to appropriate personal protective equipment. • We saw records which demonstrated there were appropriate arrangements for the removal of clinical waste. 	

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:	

- Staff we spoke with demonstrated that they understood how to prioritise patients who reported signs and symptoms of sepsis. All staff had completed sepsis awareness training relevant to their role.
- Emergency equipment and medicines were held and accessible on site.
- Reception and administration staff who handled calls to the practice and arranged appointments with the clinical team were aware of potential red flag symptoms.

Information to deliver safe care and treatment

Staff did not always have the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Partial
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"> • During our clinical searches and record reviews we identified concerns in the management of patients' records. • On reviewing the clinical system, we found 889 outstanding tasks awaiting action. The practice told us they had reviewed these tasks and that all urgent tasks had been actioned. Tasks remaining were non-urgent, routine or self-reminders, that had been kept on the action list to ensure all tasks were actioned appropriately. This caused some confusion during the inspection as the current system provided a false picture of exactly what required actioning and what had been completed. For example: We found over 269 letters awaiting action, the oldest was dated May 2022 for a request for medicines to be started, however, the practice were unable to confirm that this had been actioned. We also found 11 urgent tasks which dated from November 2021 that the practice were unable to demonstrate had been acted on. Following the inspection, we received assurances that the practice had a system in place to ensure all tasks and letters awaiting action were clearly classified into categories and there was no confusion amongst the staff of the appropriate processes to follow. • The practice held monthly practice meetings and daily huddles for staff to share any concerns. 	

Appropriate and safe use of medicines

The practice had some systems for the appropriate and safe use of medicines, including medicines optimisation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

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)	0.48	0.81	0.79	Variation (positive)
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)	7.5%	6.2%	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 and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022) (NHSBSA)	5.72	5.21	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	87.3‰	138.1‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.66	0.66	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	7.1‰	8.7‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. ¹	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. ²	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.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> • During the review of the clinical system we carried out a search for patients on high risk medicines. We reviewed patients who had been prescribed medicines to protect joints by stopping or slowing inflammatory arthritis and found 100 patients had been prescribed these medicines. We identified seven patients that had not received up to date monitoring. We reviewed a random sample of five of these patient's records and found that specific monitoring for these types of medicines had not been carried out appropriately. During the inspection we discussed our findings with the clinical lead and we received evidence to demonstrate that the patients we identified had been reviewed by the practice. However, the practice could not demonstrate that appropriate monitoring had taken place. • On reviewing patients on new oral anticoagulants (NOACs) which are medicines to help thin the blood, we found a total of 73 patients being prescribed these medicines. The clinical search showed 11 patients had not had the appropriate monitoring done in the past 12 months and nine patients had not had their liver function tests or full blood counts done in the past 15 months. Following the inspection we received evidence to demonstrate that four of the patients we had 	

Medicines management	Y/N/Partial
<p>identified as requiring monitoring had not had medicines issued and a note had been added to the clinical record, two patients records required clinical coding of blood reports, and three patients had been offered blood test appointments.</p> <ul style="list-style-type: none"> We found that patients had been over issued medications as well as the legal requirements for controlled drug prescribing were not being met. For example: Patients on medicines used to manage pain had been over prescribed and on reviewing a random sample of five records we found no evidence to demonstrate that three of these patients had received a review of their symptoms or the medicines had been checked to ensure they were meeting the patients' needs. We carried out a search of the clinical records to identify the number of patients that had been prescribed medicines for pain management. We identified 35 patients who had not received a pain management review in the past 12 months whilst on these medicines. We reviewed a random sample of five clinical records and found all patients hadn't received medication reviews, with the latest medication review on some patients' records dating back to 2020. There were appropriate arrangements in place for the management of vaccines and for maintaining the cold chain. We saw fridge temperatures were routinely monitored and vaccines reviewed at random were in date and stored appropriately. 	

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:	17
Number of events that required action:	17
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had a centralised system for the storing of policies and information which was available to all staff. The practice had developed a process of recording, acting and sharing information and learning outcomes as a team. 	

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

Event	Specific action taken
Communication failure	<ul style="list-style-type: none"> A request for urgent medicines from the palliative care team was not acted on immediately which caused a delay in patients receiving their medicines.

	<ul style="list-style-type: none"> • The event was discussed at a practice meeting and agreed all emails from the palliative care team were actioned as urgent. • All urgent requests were to be added to the duty doctor list to ensure action was taken immediately.
Fridge temperatures not being recorded appropriately	<ul style="list-style-type: none"> • Twice daily fridge readings were being frequently omitted despite being discussed with the practice team following a quarterly audit in April 22 • A reminder was sent to all staff to check fridge temperatures twice a day and for staff to be allocated this role when rooms were not in use to ensure twice daily checks were carried out. • Fridge check reminder was to be added to the first administration slot each day as a reminder to staff.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We saw examples where relevant safety alerts were shared with staff and a tracking system used to ensure they had been read and acknowledged. • The practice ran regular audits to ensure actions taken against medicine safety alerts such as those from the Medicines and Healthcare products Regulatory Agency (MHRA) were maintained. Our clinical searches confirmed these checks were in place. • We reviewed a safety alert that had been issued concerning medicines that posed a potential risk to increase the risk of birth defects and development disorders when taken during pregnancy, especially during the first trimester (up to week 12 of pregnancy), when a woman may not know she was pregnant. We carried out a clinical search to identify patients on these types of medicines and found 26 patients. We reviewed a random sample of five records and found patients had been made aware of the potential risks and alternative treatments considered. 	

Effective

Rating: Requires Improvement

At the last inspection in January 2020 we rated the practice as requires improvement for providing effective services because data showed the practice had not considered all actions to improve uptake of cancer screening and children's immunisations and patients with long term conditions and mental health conditions were not always receiving effective care and treatment. At this inspection we have continued to rate the practice as requires improvement as uptake with childhood immunisations and cancer screening rates continued to be below the minimum uptake target and we found some patients had not received regular reviews to ensure their care and treatment was adequate.

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

Effective needs assessment, care and treatment

Patients' needs were not always assessed, and care and treatment 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.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
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">• The practice could not demonstrate that patient's treatment and medicines were regularly reviewed and updated. For example: We found the practice had not identified the over ordering of controlled medicines.• We carried out a search of the clinical records to identify the number of patients that had been prescribed medicines for pain management. We identified 35 patients who had not received a	

pain management review in the past 12 months whilst on these medicines. We reviewed a random sample of five of these clinical records and found all five patients had not received medication reviews, with the latest medication review on some patients records dating back to 2020.

Effective care for the practice population

Findings

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

Management of people with long term conditions

Findings

- Patients with long term conditions were not always reviewed to ensure their treatment was optimised in line with national guidance;
- Patients requiring high dose steroid treatment for severe asthma episodes were not always followed up in line with national guidance to ensure they received appropriate care.
- Patients with asthma were not provided with care plans following a review and we also found two patients who were at high risk of gastrointestinal bleeding had not been followed up appropriately.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.

- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	74	103	71.8%	Below 80% uptake
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)	49	103	47.6%	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)	50	103	48.5%	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)	52	103	50.5%	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)	40	147	27.2%	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 a recall system in place to follow up on patients who failed to attend their appointments. There was a care co-ordinator in place who contacted patients and tried to re-arrange the appointments.

- Once a baby was born a reminder was sent to the parents about the six week check to encourage patients to attend for review and immunisations.

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)	55.4%	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)	54.3%	55.7%	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)	47.7%	57.0%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	41.7%	50.3%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Any additional evidence or comments

The practice had implemented a range of initiatives to try and encourage patients to attend for cervical screening. These included:

- A link sent to patients so they could book an appointment directly with the nurse
- Open day walk in session
- Running clinics on flu immunisation days
- Extended hour appointments with the nurse on Wednesday evening to support people who were at work.

Monitoring care and treatment

The practice had some quality improvement activity.

	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

<p>The practice had carried out an audit on diabetes during 2020 to identify the following:</p> <ul style="list-style-type: none">• Patients with a HbA1c more than 48mmol who had not had their blood tests repeated• Patients who had had two or more HbA1c results greater than 48 who had not been coded as diabetic. <p>The audit found 25 patients who were in these two categories. A review of these patients was carried out to ensure patients were reviewed regularly an action plan was put in place which included a three month recall being added to patients' records that had a HbA1c blood test result greater than 48 that was not known to be diabetic and alerts were added to patients records to highlight abnormal blood test results.</p> <p>A repeat of the audit in 2021 found some improvements, however 14 patients were found to fit the above criteria. A further review was completed and the practice found some patients had failed to attend appointments, others had been clinically coded as abnormal but not followed up appropriately. A plan was put in place to ensure patients were followed up appropriately following abnormal blood test results.</p>

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"> • A system was in place to monitor and review staff training and we saw high levels of completion rates for training specified as mandatory by the provider. This included level three training for all clinical staff in safeguarding. • Discussion with clinical and non-clinical staff demonstrated awareness and understanding in areas such as safeguarding and responding to an emergency. • Clinical staff had opportunities to attend local networks and online events to help maintain skills and development. • Staff had received appraisals. Information from the outcome of appraisals was used to support staff who had expressed interest in new roles. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Regular meetings were held with community teams to ensure patients received a co-ordinated approach to meet their needs. 	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had an active social media page which they used to share information and promote healthy lifestyle advice. 	

Consent to care and treatment

The practice was able to demonstrate that it obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Partial
Explanation of any answers and additional evidence, including from clinical searches: <ul style="list-style-type: none"> We carried out a clinical review of patients notes where a DNACPR decision had been recorded, however we found no DNACPR forms on the records. Following the inspection, the practice told us they were going to ensure that a copy of the appropriate form was kept on the patient record. 	

Caring

Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	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
NHS UK	The practice had received positive reviews which highlighted the helpfulness of staff and how patients felt listened to.

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

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 (01/01/2022 to 30/04/2022)	85.2%	78.9%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	80.2%	76.9%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	93.9%	89.4%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	52.1%	62.2%	72.4%	Tending towards variation (negative)

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

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

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

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 (01/01/2022 to 30/04/2022)	93.6%	85.1%	89.9%	No statistical variation

	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.	The practice had identified 170 of their patients as carers, this represented 1.5% of the practice's patient list.
How the practice supported carers (including young carers).	Carers were invited for health checks and flu vaccinations. There was a carers noticeboard in the reception waiting area which provided information on local support groups.

How the practice supported recently bereaved patients.	The practice had a bereavement pack that was sent out to families to provide them with information.
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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: Good

At the last inspection in January 2020 we rated the practice as requires improvement for providing responsive services due to patient feedback which highlighted access was an issue. At this inspection, we found patient feedback had improved, this was demonstrated through the national GP survey and the practice were regularly monitoring telephone calls to try and reduce waiting times. We have now rated the practice as good for providing responsive services.

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	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm 6.30pm to 8pm (extended hours)
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Appointments available:	
Monday	9am to 12pm / 4pm to 6pm
Tuesday	9am to 12pm / 4pm to 6pm
Wednesday	9am to 12pm / 4pm to 6pm 6.30pm to 7.50pm (extended hours)
Thursday	9am to 12pm / 4pm to 6pm
Friday	9am to 12pm / 4pm to 6pm

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> Patients had a named GP who supported them in whatever setting they lived.

- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Additional nurse appointments were available until 8pm on a Wednesday for school age children so that they did not need to miss school.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice was open until 8pm on a Wednesday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was part of a larger organisation. Appointments were available Saturday from 9am to 12.30pm.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. The practice had implemented a project to improve access for vulnerable patients. The aim of the project was to implement regular consultations to address patients physical, mental and social needs. The practice carried out a search of the clinical system to identify patients who had been identified as vulnerable. A multi-disciplinary team worked together to ensure patients were provided with the appropriate care and reviews. The practice had reviewed a 100 patients since the project began and have dedicated clinical slots for staff to use for patients who fall into this category. The practice has also introduced a routine home visit list which was reviewed on a weekly basis to ensure if patients could not attend the practice they had the appropriate reviews completed at home.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had recently recruited a third practice nurse to join the team and provide more appointments to patients. • The management team told us that as they were part of a larger organisation, they had access to staff to support when there was a need. • The practice website provided a range of information that could be changed into different languages to support patients who did not have English as their first language. • The practice had been involved in an initiative to provide vaccinations to homeless people. Working in conjunction with a local homeless charity the practice had clinicians to vaccinate people. A total of 50 people were vaccinated in two hours. 	

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

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 (01/01/2022 to 30/04/2022)	44.1%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	44.8%	46.1%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	47.4%	48.6%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	61.2%	64.8%	71.9%	No statistical variation

Any additional evidence or comments

The practice had a monitoring system in place to review the number of telephone calls received and the time to reply. A call back facility was in place for patients who could not wait to speak with the practice. Evidence provided by the practice showed that during August 2022, they answered 82.8% of calls.

Source	Feedback
NHS UK	Mixed reviews, some comments related to difficulty in getting appointments, however patients commented positively on the care they received and the helpfulness of staff.
Friends and Family Test	The practice analysed the results of the Friends and Family Test. Results showed that during January to July 2022, 80 patients had provided feedback with 90% of patients were extremely likely or likely to recommend the practice.

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.	12
Number of complaints we examined.	Three
Number of complaints we examined that were satisfactorily handled in a timely way.	Three
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Information about how to make a complaint or raise concerns was available to patients. The practice informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint. The practice had a complaint policy and procedures in place which were available and easily accessible to staff. Complaints were discussed at the practice meetings and any trends and learning identified. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
Not listened to during consultation	<ul style="list-style-type: none"> The practice investigated the complaint. They reviewed the patient's records and spoke with the staff that were involved. Learning was shared with relevant staff including the importance of listening to the patient and taking a detailed history.
Long waiting time	<ul style="list-style-type: none"> .The practice investigated the complaint and discussed it at the practice meeting. Staff were reminded to keep patients upto date if appointments were running late.

Well-led

Rating: Requires Improvement

We have rated the practice as requires improvement for providing well-led services as we found the processes for the management of quality and risk required strengthening to mitigate risk.

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 management team were aware of the challenges and had a realistic strategy and supporting objectives to respond to challenges as well as maintaining quality and sustainability.• Staff we spoke with explained that the leadership team were visible and approachable. Staff described the practice team as supportive. The leadership team demonstrated a genuine passion to tackle health inequalities and there was a systematic approach with strong governance arrangements when working with stakeholders to improve care outcomes.• To ensure a team approach and to distribute operational responsibilities, the GP practice was part of a larger organisation. This supported the practice in to monitor quality and performance and acted as the overarching governance framework bringing local practices together.• Staff reported that they felt well led and part of a team. There was strong collaboration and support across all teams and a common focus on improving the quality of care and people's experiences.• Staff met regularly to discuss any issues or complex cases and to offer and receive peer support. A range of meetings were in place to discuss issues and share updates with staff.	

Vision and strategy

The practice had a vision and strategy to provide high quality sustainable care, however they were unable to demonstrate the vision was being met.

	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.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• There was a mutual vision among the leadership team and staff to provide safe, high quality care. However, clinical searches completed during the inspection showed some patients had not received the appropriate care and monitoring.	

- As the practice was part of Modality Partnership, they had a joint vision and set of values with the practices in their network. The values were commitment, accountability, respect and excellence. Their aim was to meet the growing needs and expectations of patients; without losing continuity of care. On speaking with staff they was a whole team approach to ensuring these values were implemented and sustained.
- Staff we spoke with demonstrated clear understanding of the practice vision, value and strategy and applied this in their role.

Culture

The practice culture did not always effectively support high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Partial
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"> • We found that the vision and values were not always adhered too, with some patients not receiving the appropriate follow up and reviews. • The practice tried to mitigate possible future risks by discussing incidents and complaints at staff meetings to share learning. • Staff were very positive about working at the practice. Staff told us they had received constant support from the GPs, managers and team. There was a positive attitude throughout the entire workforce which enabled the smooth running of the practice. • Staff had clear roles and responsibilities and staff wellbeing was discussed as part of the appraisal process. • The practice encouraged staff to report incidents and share learning. Staff told us they had no concerns in raising issues and felt well supported when reporting incidents. 	

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

Source	Feedback
Staff	Staff told us that the management team were supportive, approachable and always willing to listen. There was a team environment and everyone worked well together.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice had systems in place to ensure all staff were clear on their roles and responsibilities. Induction plans for new staff were tailored to the individual and there was a clear structure and accountability process in place. Communication was effective and organised through structured, minuted meetings. Governance and performance management arrangements were proactively reviewed and reflected best practice. All clinicians met regularly to discuss work prioritisation and vulnerable patients as well as difficult cases and current events. There was a good relationship with community teams to ensure patients received effective co-ordinated care. The practice had a range of systems in place to ensure the practice was efficient. The practice was part of a large organisation of practices and the management team ensured processes were co-ordinated and any changes were implemented through a team approach. 	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Partial
There was a quality improvement programme in place.	Partial
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:	

- The practice had some assurance systems in place however we found these to be ineffective in the safe care and management of some patients. For example: we found some patients on high risk medicines and those with long term condition had not received the appropriate monitoring.
- Due to the clinical findings from the inspection we were unable to gain assurances that the practice had a system in place to manage performance and the quality of care.
- The practice had some quality improvement in place. Audits were carried out in a range of areas to monitor the services provided. We reviewed an audit on patients with diabetes which had identified patients that required a review. However, the results of clinical searches carried out during the inspection showed some patients with long term conditions were not being monitored appropriately.
- The provider had undertaken several risk assessments relevant to the provision of clinical care, including infection control and premises risk assessments. Recommendations from risk assessments had been actioned.
- Regular meetings were held with all managers across the group of practices to share information and ensure information was shared across the teams. Staff meetings were held on a regular basis.
- There was an open culture and clear learning culture within the practice. The practice encouraged the reporting of incidents, to identify ways in which the practice could continually improve.

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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The leadership team told us that they had continued services throughout the COVID-19 pandemic and had been able to manage staff absences. • All patients who requested to see a GP were first given a telephone appointment. Following the telephone review, the GP would make a clinical decision if a face to face appointment was required. 	

- Face masks were available if patients arrived without one and hand sanitisers were in place throughout the building.
- Patients who were considered vulnerable had alerts on their clinical records to identify them.
- The practice had held an event during the pandemic to link local community leaders with clinical staff and patients to answer questions about COVID-19 vaccinations. A range of video information had been implemented to answer patients' questions.
- The practice had organised vaccination clinics at a local practice, but patient feedback showed difficulties in accessing this particular site. In response to the feedback the practice started a waiting list of patients who required vaccination and set up pop up clinics at the practice to provide a vaccination service to patients. Due to the success of the pop up clinic, the practice continued to offer this service during the extended hours each Wednesday.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial
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 used clinical audits to drive performance and demonstrate improved outcomes for patients. However, we found some patients with long term conditions were not followed up appropriately. • A range of safety mechanisms had been implemented to ensure risks were mitigated. This included a range of risk assessments to ensure patient safety. 	

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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • There were policies in place to support staff with utilising digital services securely and effectively. This included the process and procedures for telephone, email and video consultations. • Online consultations took place in consultation rooms with the doors closed to protect the patients' privacy. 	

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.	N
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 tried a range of initiatives to encourage patients to join the participation group. This included patients being asked during flu clinics in 2020, to add their email addresses to be contacted to be part of a virtual PPG meeting. The practice was able to build a list of 30 patient email addresses. A three monthly invite was sent from 2020 to June 2022. The practice had one person log in to the first meeting in December 2020 and following this the following three meetings, the practice were unable to engage with any patients. • Due to the pandemic the practice were unable to engage with patients, so alternative methods were used which included virtual messaging. The practice continued to send out important information about changes through telephone messaging and feedback on the telephone system. • The practice have reviewed their initiatives to further engage with patients. An action plan has been implemented which included reception staff encouraging patients to join the PPG. A dedicated notice board was in place with information on the group and an open evening engagement event was being organised and invitations were sent to a random patient group which incorporated different age groups. 	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y

Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• An effective process was in place to ensure all staff were up to date with the practice's mandatory training. Staff told us they were given the opportunity to develop and learn.• Continuous monitoring of training and development was carried out by the management team and learning from events, complaints and compliments was shared to enable lessons to be learnt and improvements to services were acted on.	

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.