

# Care Quality Commission

## Inspection Evidence Table

### East Park Medical Centre (1-9667805535)

Inspection date: 25 and 27 July 2022

Date of data download: 21 July 2022

## Overall rating: Good

### Safe

Rating: Good

#### 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.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>• There were safeguarding leads for adults and children with deputy leads.</li><li>• There was an up to date and comprehensive safeguarding policy, which covered all aspects of safeguarding and identified who to contact regarding any safeguarding concerns.</li><li>• Information regarding safeguarding impacting on patients was recorded appropriately, in line with confidentiality guidance.</li><li>• The practice employed an adult and young people's lead, who liaised with schools and parents regarding any safeguarding issues. They would also write up relevant safeguarding reports for sign off by the deputy safeguarding lead and ensure all the registers and records were up to date.</li><li>• Safeguarding clinical supervision for staff was provided by the deputy safeguarding lead.</li><li>• Each member of staff had a "safeguarding passport", which is a national competency framework to support safeguarding practice.</li></ul>	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> <li>We were provided with several examples of safeguarding concerns relating to children and young people that they had managed appropriately.</li> </ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>There was a comprehensive recruitment policy, which included both a business impact assessment and an equality impact assessment.</li> <li>Recruitment checks also included those for the GP locums they used.</li> <li>We reviewed three staff personnel files and found they included relevant information, such as evidence of qualifications, references, disclosure and barring service checks, photographic identification and interview notes.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: May 2022	Yes
There was a fire procedure. Date of fire risk assessment: 14/07/2022	Yes
Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Testing of the fire alarm and emergency lighting system was undertaken on a weekly basis.</li> <li>The practice had participated in an unplanned fire evacuation two weeks prior to the inspection, whereby the whole premises were evacuated. The only action identified as a result, was to ensure that the book for logging visitors' in and out of the practice was removed from the premises when an evacuation occurred, to check that all visitors were accounted for.</li> </ul>	

## 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.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 10/08/2021	Yes

The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• There was a range of policies and procedures relating to infection prevention and control (IPC). These included safe management of waste, hand hygiene, aseptic technique and decontamination of equipment.</li> <li>• There was a nominated IPC lead who had been appropriately trained and undertook IPC audits.</li> <li>• There was an annual IPC audit undertaken across both sites. In addition, there were monthly checks of rooms (the last one being 5 July 2022). We saw actions had been identified and completed, for example the replacement of a lightbulb in one of the rooms.</li> <li>• Hand-washing audits were undertaken on staff and updates given regarding hand-washing techniques.</li> <li>• Nursing staff were audited regarding their aseptic technique (this is a procedure that minimises the risk of introducing an infection, such as in wound care). The last audit had been carried out on 14 July 2022 and no actions had been identified.</li> <li>• Regular cleaning checks and audit were carried out. Any areas of concern were communicated to the persons responsible for cleaning of the practice.</li> <li>• There were processes in place for the Control of Substances Hazardous to Health (COSHH).</li> <li>• Monthly checks relating to the prevention of legionella were carried out, such as the flushing of taps. The latest legionella risk assessment had been undertaken on 18 July 2022.</li> <li>• The practice had a system in place for the decontamination of equipment, such as peak flow meters. Cleaned equipment was bagged and labelled with a green sticker. Dirty or used equipment was placed into a box which was labelled with a red sticker.</li> <li>• Masks and hand gel were available for staff, patients and visitors to the practice.</li> <li>• Other personal protective equipment (PPE), such as gloves and plastic aprons, was also available.</li> <li>• Staff continued to wear masks on the premises, in line with COVID precautions.</li> </ul>	

## 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.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes
Explanation of any answers and additional evidence:	

- We were informed that due to the practice experiencing some issues regarding staffing levels, they were using regular GP locums to support clinical work. By using the same locums this supported consistency and continuity of care for patients.
- There were induction processes for new starters and locums. One member of staff told us of the induction process they had undertaken for their role, and how comprehensive it had been and the support they have received from staff.
- At the time of our inspection, the practice was undertaking a recruitment campaign.

## 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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• At the time of our inspection, as a result of staffing shortages, there was a backlog of approximately 200 patient records to be summarised. Measures were in place to address the issue.</li> <li>• Action had been taken to ensure that any outstanding records did not relate to patients who were deemed to be at risk, vulnerable or had complex health needs. There was information recorded on the patients' electronic records, via a GP to GP system, to support the delivery of safe care and treatment.</li> </ul>	

## Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR	0.80	0.82	0.79	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
PU) (01/04/2021 to 31/03/2022) (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). (01/04/2021 to 31/03/2022) (NHSBSA)	8.5%	6.7%	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)	4.39	4.70	5.29	Tending towards variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	163.0‰	111.8‰	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)	0.55	0.48	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	8.9‰	4.9‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
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.	Yes

Medicines management	Y/N/Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	n/a
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• There was a cold chain policy, which identified what staff should do if vaccine refrigerator temperatures went out of range.</li> <li>• The practice employed pharmacy technicians to support them with safe medicines management.</li> <li>• Non-medical prescribers had regular clinical supervision and used a drug formulary to prescribe. They had daily access to a GP should they need to seek further advice or clarification.</li> <li>• Standard operating procedures regarding medicines were in place for the physician associate role.</li> <li>• The practice had commenced non-medical prescribers' meetings. We saw from the latest meeting minutes on 05/07/2022, that self-audit of antibiotic prescribing against local guidance was planned for the October meeting.</li> </ul>	
Any additional evidence or comments	
<p>As part of our inspection, on 25 July 2022 we conducted a series of clinical searches to assess the practice's procedures around medicines management and prescribing. The remote electronic review of the searches was undertaken by the CQC GP specialist advisor. The searches were visible to the practice. The following searches were carried out on:</p> <ul style="list-style-type: none"> <li>• Patients who were prescribed methotrexate, which is a disease-modifying antirheumatic drug (DMARD). The search showed that patients had received appropriate monitoring in line with guidance.</li> <li>• Patients who were prescribed a potassium sparing diuretic, such as spironolactone. The searched showed that 55 patients were prescribed these medicines, of which 13 had not had all their required blood tests. We reviewed five patients and saw that patients had either been invited for their blood tests or had refused to participate.</li> </ul>	

Medicines management	Y/N/Partial
<p>The practice was informed of the findings. They told us how they were addressing the issues and following-up the patients. We were assured that all necessary actions were being taken to ensure patient safety.</p>	



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

### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	30
Number of events that required action:	30
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>• The incident reporting policy contained a copy of the incident reporting form.</li><li>• Incidents were recorded internally and were collated according to the nature of the incident, such as medicines management and patient safety. This supported the practice in identifying any themes or trends and action them accordingly. We saw that some medicine management incidents related to patients being discharged from secondary care without a supply of their medication, thereby causing a delay in patients receiving treatment. The practice had subsequently provided the relevant prescription for those patients.</li><li>• Incidents were reported on DATIX (a local and national reporting system), which allowed for identification of trends more widely across Leeds.</li><li>• Staff were aware of the incident reporting process and were encouraged to raise any concerns. They told us that incidents were discussed in meetings and any learning disseminated as necessary.</li></ul>	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>• The safety alert protocol described the process for managing safety alerts, including those received from the Medicines and Healthcare Products Regulatory Agency (MHRA).</li><li>• Patient safety alerts were a standard agenda item at practice meetings.</li><li>• As part of the clinical record search, undertaken on 25 July 2022, we reviewed an MHRA alert from April 2022 relating to women of childbearing age being prescribed teratogenic drugs (medicines which could cause birth defects). There were 20 patients identified, of five that we reviewed we found there was no clearly recorded evidence that those patients had been advised accordingly. The practice was made aware and, subsequently, put mechanisms in place to inform the patients.</li></ul>	



## Effective

## Rating: Good

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 assessed, and care and treatment was 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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>• A clinical decision support tool was integrated into the clinical system, which allowed easy access to the latest evidence-based guidance. Locally used templates were also embedded into the system. These supported safety, consistency and clinical effectiveness.</li><li>• The practice employed an adults and children lead/young person's champion. This member of staff worked closed with schools and attended multi-agency meetings, particularly regarding education, health and care (EHC). EHC plans are for children and young people whose special educational needs (SEN) require more help than would normally be provided in nursery or at the level of SEN support in school.</li><li>• The champion supported schools and families by signposting them to the most appropriate agency. This could relate to various issues, such as children not attending school, child behavioural difficulties, eating disorders or safeguarding. They would meet with parents/guardians to gather information using a holistic approach. They maintained a register of referrals made, such as those</li></ul>	

to Mindmate (a Leeds based organisation who supported young people with their mental health and wellbeing) and followed up any areas that were outstanding, such as blood tests.

## Effective care for the practice population

### Findings

- Clinicians worked with other health and care professionals to deliver coordinated packages of care.
- The practice had access to midwifery and health visiting services to support families and children.
- The district nursing teams provided some support for patients who were housebound.
- New patient checks and appropriate health assessments were available, including NHS health checks for patients aged 40 to 74 years. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Influenza, pneumonia and shingles vaccinations were available for patients who fitted the criteria.
- Patients with a learning disability were invited for an annual health check.
- There was a system in place to identify people who misused substances.
- Patients with poor mental health, including dementia, were assessed, monitored and referred to appropriate services.
- A clinical tool was used to identify older patients who were living with moderate or severe frailty. Those identified were referred to the primary care network's frailty advanced care practitioner as needed. The patients received a full assessment of their physical, mental and social needs.
- 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 access to a primary care network patient ambassador to whom patients could be referred for additional support as needed.
- During the pandemic, the practice had delivered a COVID vaccination clinic from their premises. This had enabled local people to easily access services and encouraged uptake of the vaccination.

## Management of people with long term conditions

### Findings

As part of our inspection, on 25 July 2022, we conducted a series of remote clinical searches to assess the practice's procedures for the management of patients with long-term conditions. A review of the searches was undertaken by the CQC GP specialist advisor (SpA) without visiting the practice.

In general, our GP SpA found the management of patients with long-term conditions was good, particularly given the challenges of service provision during the pandemic and some patients not wishing to attend the surgery. The majority of patients we reviewed who had a long-term condition, such as asthma or diabetes, had been followed-up appropriately. Some patients had not attended their appointments and were being followed-up by the practice.

We were informed that:

- Patients with a long-term condition were offered a structured review, in line with the relevant guidance, to check their health and medicines needs were being met.
- Patients were seen and reviewed as befit their ongoing needs, for example if they were experiencing an exacerbation of their illness.
- The practice used the local clinical commissioning group's template for recording long-term reviews and patient information.
- Adults with either newly diagnosed, or at risk of, cardiovascular disease were offered statins in line with local guidance.
- Patients with asthma and chronic obstructive pulmonary disease (COPD) were provided with management of care plans. Prescriptions for rescue medications were available for patients as necessary.
- Staff who were responsible for the care, treatment and reviews of patients with a long-term condition had received specific training.
- There was a process in place for following-up patients who did not attend their appointments.
- The practice had purchased a "pod", which was to be located in the patient waiting area. The pod would enable patients to do their own testing, such as blood pressure and oxygen saturation rates. A printout would be generated and handed into the reception staff and any areas of concern would be escalated to the GP. Information would automatically be inputted into the patient's electronic record. At the time of our inspection, the practice was waiting for it to be installed in line with local processes.

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)	88	108	81.5%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	73	126	57.9%	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)	71	126	56.3%	Below 80% uptake
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR)	72	126	57.1%	Below 80% uptake

(01/04/2020 to 31/03/2021) (NHS England and Improvement)				
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	67	131	51.1%	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
<ul style="list-style-type: none"> <li>The practice is located in an area of high deprivation with a multicultural community. There is published evidence (accessed via NHS England) which correlates low uptake childhood immunisation rates with deprivation and certain ethnicities. This was also evidenced by the contrast in uptake rates at the provider's other location which was based in an area of very low deprivation.</li> <li>Despite these figures, we saw evidence that the practice consistently worked to improve the uptake of childhood immunisations. The practice communicated with school nurses, health visitors and midwives to encourage parents to present their children for immunisations.</li> <li>There was an identified member of staff who maintained a spreadsheet to monitor attendance for immunisations. Anyone who did not attend was then contacted and offered a new appointment. They also chased up information regarding patients who had migrated into the country and whose past medical history, including immunisation status, was not readily available. We were told of the difficulty in obtaining and the recording of information when children had received immunisations elsewhere, such as their country of origin.</li> <li>At the time of our inspection, the provider was engaging with local university students to have letters translated into the various languages, which they could send to patients.</li> </ul>

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	60.3%	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)	56.1%	64.0%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	57.7%	65.8%	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)	51.7%	52.2%	55.4%	No statistical variation

### Any additional evidence or comments

- The practice was located in an area of high deprivation with a multicultural community. There is published evidence (accessed via the British Medical Journal) which correlates low uptake cancer screening rates with deprivation and certain ethnicities. This was also evidenced by the contrast in uptake rates at the provider's other location which is based in an area of very low deprivation.
- Pre the COVID pandemic, the practice had been trying to address the lower uptake rates for cancer screening programmes. However, the pandemic caused a hiatus in this. As the pandemic eased, the practice offered a bi-monthly Saturday morning cervical screening clinic, to enable women easier and more confidential access. Patients who do not attend their appointments are followed up and information given.
- The provider informed us they were looking to recruit a nurse who specialised in women's health, who could support women in a way which befitted their culture.

### Monitoring care and treatment

**The practice had a 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.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

### Any additional evidence or comments

- The practice undertook clinical and non-clinical audits. Findings from these were used to improve patient care and service delivery. We reviewed two audits, both of which were undertaken on a quarterly basis:
  - May/June 2022 relating to medication reviews. We saw that in not all instances the appropriate coding or template had been used. The practice had identified the lack of consistency and was raising awareness of correct usage with clinical staff. This would be evaluated at the next audit.
  - June 2022 relating to patient mortality. We saw that out of 10 patients, seven had been expected who had all had an end of life pathway in place. Only one out of the 10 patients did not have a do not attempt cardiopulmonary resuscitation (DNACPR) in place; this was one of the unexpected deaths. No issues or concerns had been identified as a result of the audit.
- The practice participated in the clinical commissioning group's quality improvement schemes.
- They engaged with the local primary care network to improve services for their patient population.

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• There was an up to date appraisal policy which identified that staff received annual appraisals through a formalised process.</li><li>• We saw that all staff received mandatory training and other training relevant to their role. A training matrix was maintained to ensure that staff were up to date.</li><li>• We were informed of some instances where they had been required to manage staff performance issues.</li><li>• Due to recruitment issues, the practice had undertaken an open day to encourage people to attend the practice and find out more about the non-clinical roles available. As a result of this day, and in line with recruitment procedures, the practice had subsequently recruited five new staff.</li><li>• Recruitment of staff remained an ongoing action and interviews were planned for a date post-inspection.</li></ul>	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
Explanation of any answers and additional evidence:	



- At the time of our inspection, the practice had registered patients who were residents in a number of nursing or residential care homes; one of which was for young people who had complex disabilities. The practice liaised on a regular basis with staff of those homes, to ensure that care and treatment was provided appropriately for the patients who resided there.
- Weekly 'ward rounds' were undertaken, to enable patients to be reviewed in their own environment.
- We were informed that staff had attended one of the homes, where the majority of patients had a learning disability. This was to deliver advice and information regarding health lifestyle, including diet.
- The homes had access to a dedicated telephone number and email address to contact the practice, to avoid waiting on the telephone.
- The provider had a community care bed contract, which was delivered from East Park Medical Centre (community care beds are places where patients are able to be discharged from hospital but not well enough to go home). Primary care services were delivered by staff to those patients until they were well enough to be discharged. This included undertaking a weekly visit to the ward, any appropriate reviews or urgent visits.

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes

## Consent to care and treatment

### The practice could 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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes



Explanation of any answers and additional evidence:

We reviewed a sample of four patients who had a DNACPR recorded in their patient record. We found information was appropriately obtained and recorded, including where one patient had rescinded their original decision.

## Caring

**Rating: Good**

**Kindness, respect and compassion**

**Staff treated patients with kindness, respect and compassion.**

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

## National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	85.6%	90.4%	89.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)	85.3%	89.1%	88.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	90.6%	96.2%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	64.9%	84.6%	83.0%	Variation (negative)

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

### Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes

### 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)	84.1%	93.4%	92.9%	Tending towards variation (negative)

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

Carers	Narrative
Number of carers identified.	225 registered patients had been identified as being a carer. Their electronic patient record had been coded to alert staff to this.
How the practice supported carers (including young carers).	There was a notice board with information for carers located in the practice patient waiting area. Carers were encouraged to register with the Leeds yellow card scheme and were referred to Carers' Leeds. Carers were invited for relevant vaccinations, such as those for protection against influenza and COVID. Support was provided as befit the individual needs of the carer.

How the practice supported recently bereaved patients.	Individual support was offered, as needed, to patients who experienced bereavement. We were given several examples of how they had supported end of life care and the bereavement process of their families.
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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.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes

## Responsive

## Rating: Good

## Responding to and meeting people's needs

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

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

### Practice Opening Times

Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm

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

- Appointments for patients were available from 8am to 5.45pm Monday to Friday. Clinicians worked staggered shifts to ensure appointments were available all day.

- The practice delivered a bi-monthly cervical cancer screening clinic on Saturday between 8am and 12 midday.
- Patients had access to extended hours appointments at evenings and weekends at hubs based in Leeds, which were organised by the local confederation.
- Out of hours cover was provided by Local Care Direct. Patients were directed to contact NHS 111 when the practice was closed.
- 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.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- The practice liaised with the district nursing team to support those patients who were housebound.

## 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	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• There was a call centre based at East Park Medical Centre, where all calls into the practice were handled. This was located away from the reception area, which supported patient confidentiality.</li> <li>• The lead GP conducted a “sit and wait one-stop” clinic on Fridays from 9am. Patients also had access to a healthcare assistant and a physician associate at the clinic. This enabled patients to be seen by the most appropriate clinician. Patients who contacted the practice were offered</li> </ul>	

an option to attend the clinic. We were informed of the flexibility this provided for some patients who accessed services regularly or who had multiple needs. As there were no appointments, time was given to patient as befit their need. If it was identified that patient required blood tests or an electrocardiogram at that time, the tests would be undertaken on the same day, to avoid the need for making a separate appointment. We were given examples of positive impacts on some patients and a reduction in their out of hours attendances or non-attendance of booked appointments.

- We saw a small survey the practice had conducted with 13 patients who had attended the “sit and wait” clinic:
  - 92% of the patients had been seen by the GP
  - 69% of patients thought the service was “excellent”
  - 31% of patients thought the service was “good”
- The practice designated patients as being either tier one or tier two to determine how long the appointment should be. For example, tier two patients tended to be more complex and were given a longer appointment.
- We were informed of the current issue the practice was experiencing when using telephone interpreter services. Due to a lack of available staff at that service, there were often occasions when an interpreter was not available at the time of the patient’s appointment. This meant that a second appointment had to be made. Consequently, some appointments were being wasted due to the issue. It had been raised with the appropriate organisation.

## 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)	51.3%	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)	46.5%	71.0%	70.6%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	50.3%	67.4%	67.0%	Tending towards variation (negative)
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)	68.2%	82.4%	81.7%	Tending towards variation (negative)

### Any additional evidence or comments

- The practice offered a range of appointments throughout the day from 8am to the last appointment at 5.45pm each weekday.
- The practice had reviewed the telephone process and had developed a team of call handlers, away from patient facing areas. However, this team was still in its infancy with some staff still undergoing training. We were informed they were recruiting additional staff to the team. The practice anticipated that the new team would improve the patient experience when telephoning 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.	6
Number of complaints we examined.	6
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Of the six complaints received this year, five of them were still ongoing investigation, some of these were related to one another.</li> <li>• The manager had four appointments allocated to them each week, where patients could speak directly to them to raise any concerns. We were informed that as a result, they were able to deal with those concerns at that time, without any further action required.</li> </ul>	

Example(s) of learning from complaints.

Complaint	Specific action taken
A blood sample had been left in a room and not taken to the collection area, necessitating patient to return for repeat blood tests.	Clinicians were advised that all blood samples be taken to the appropriate area and placed in the collection bag before the time of collection. A reminder was added to the appointment system to remind clinicians of this.
A patient was unable to get an appointment due to high number of telephone calls.	All administrative staff were instructed to answer the telephones in the morning at 8am for an hour, to reduce the call waiting times.

## Well-led

## Rating: Good

### Leadership capacity and capability

**There was compassionate, inclusive and effective leadership at all levels. Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>The practice had an experienced leadership team in place, who understood both the local and national challenges to healthcare.</li><li>The practice was responsive and proactive to feedback during the inspection process and acted immediately upon findings. For example, issues relating to patients identified as part of our clinical search for where immediately actioned.</li><li>There was succession planning in place, regarding any changes in management or leadership.</li></ul>	

### Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>The practice mission was to match the delivery of health services to the needs of the community they served; to reinvest profit to improve and expand the services; to become self-sufficient financially and developmentally and known as a recognised centre of Clinical Excellence.</li><li>The provider had a passion to address health inequalities in the local community. This was supported by staff working at the practice.</li></ul>	



## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>Staff had access to both an internal and external to the organisation Freedom to Speak Up Guardian.</li> <li>Staff told us they felt supported by the GPs and practice manager and were encouraged to raise any concerns as they arose.</li> <li>Staff described a culture of strong collaboration, team-working and support across all staff and a common focus on improving the quality and sustainability of care and people's experiences.</li> <li>There was an open-door policy for the manager and lead GP and a 'no-blame' culture in the practice.</li> <li>A daily huddle was built into the staff rota, where information was cascaded and concerns could be raised.</li> </ul>	

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

Source	Feedback
Staff questionnaires and interviews	<p>We spoke with several members of staff during the inspection and received completed staff questionnaires. Staff informed us that:</p> <ul style="list-style-type: none"> <li>They felt supported professionally and personally.</li> <li>They had access to the equipment and training necessary to enable them to perform their roles well.</li> <li>The manager and lead GP were approachable and supportive.</li> <li>They enjoyed working at the practice, worked well as a team and were supportive of one another. They were proud of how "staff had pulled together" throughout the COVID pandemic to deliver services to patients.</li> </ul>

## 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.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Communication with staff was through a variety of platforms, such as meetings, emails, text messaging and daily conversations in the practice.</li> <li>• There was a range of meetings where external health care professionals attended, such as health visitors. Minutes of these meetings were available for staff to read.</li> <li>• There were systems in place to support the monitoring and tracking of health and safety, recruitment and training systems and processes.</li> <li>• The practice had nominated clinical leads for key areas, such as the safeguarding of adults and children and infection control, whom staff could contact for specialist advice and support.</li> <li>• Staff we spoke with understood their individual roles and responsibilities and knew who to contact if further advice was required.</li> <li>• We saw new staff had received a role specific induction when they had commenced, and existing staff had undertaken an appraisal.</li> <li>• Succession planning for the practice was discussed at board level.</li> <li>• We were informed of the plans to “grow their own staff” and were looking at setting up an apprentice scheme to support the development of staff.</li> <li>• There were monthly governance meetings, which were minuted, and information cascaded to staff as appropriate.</li> </ul>	

## Managing risks, issues and performance

**The practice had clear and effective processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence:	

- Staff were informed of any changes to service delivery which could impact on their day to day work.
- Members of staff told us of the risk assessments they had undergone to support them throughout the pandemic
- All policies included both a business impact assessment and an equality impact assessment.

### **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.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• All backlog of activity caused by the pandemic had been addressed. However, there were still some outstanding patient records which were required to be summarised. We were informed the practice were taking steps to address this.</li> <li>• Personal protective equipment (PPE) was available for staff, patients and any visitors to the practice. Staff continued to wear masks and patients were asked to wear a mask when entering the premises.</li> <li>• At the time of our inspection, a member of staff informed us they worked remotely from home. A risk assessment had been completed and they had been provided with the necessary IT equipment, such as a laptop and mobile telephone.</li> <li>• The provider had introduced a shift pattern for clinicians, rather than sessional working. For example, 8am to 4pm or 10am to 6pm. This enabled the practice to offer appointments throughout the whole day and ensured there was always a clinician on site.</li> </ul>	

## 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.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes

## Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes

## Engagement with patients, the public, staff and external partners

**The practice 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.	Yes
The practice had an active Patient Participation Group (PPG).	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence:	

- We were informed that throughout the pandemic, the PPG did not engage frequently. Since the easing of the pandemic, the practice has been proactive in reinstating the PPG. Consequently, they had a list of patients who wanted to participate and had plans to recommence meetings.

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The provider had a passion for health improvement and reduction in health inequalities. As a result, they were working with another practice looking at the impact of social issues on health.</li> <li>• They had signed up for the Trailblazer Deprivation Fellowship Scheme, which enabled them to have access to a paid GP who could focus on work relating to health inequalities.</li> </ul>	

#### 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 practices 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.
- **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.