

Care Quality Commission

Inspection Evidence Table

Oldfield Surgery (1-569083319)

Inspection date: 26 August 2022

Date of data download: 12 August 2022

Overall rating: Requires Improvement

At this inspection in August 2022, we rated the practice as Requires Improvement because:

- The provider was unable to demonstrate that appropriate monitoring of patients prescribed high-risk medicines was being carried out consistently when prescribing.
- Not all patients with long-term conditions, specifically asthma, chronic kidney disease and hypothyroidism, had received the required monitoring in line with national guidance.
- There was evidence that the process for managing safety alerts was not being followed appropriately to ensure patients were protected from harm.

Safe

Rating: Requires Improvement

At our previous inspection in July 2021, we rated the practice as Requires Improvement for providing safe services. This was because:

- The practice's systems and processes in relation to management of medicines required further embedding.
- There were gaps in the systems for ensuring staff recruitment was managed appropriately.

At this inspection in August 2022, we rated the practice as Requires Improvement for providing safe services. We found:

- The provider was unable to demonstrate that appropriate monitoring of patients prescribed high-risk medicines was being carried out consistently when prescribing.
- There was evidence that the process for managing safety alerts was not being followed appropriately to ensure patients were protected from harm.
- Incoming outstanding abnormal patient results were not always reviewed and supervised by a clinical lead to ensure safety netting.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a safeguarding system and policy in place for vulnerable adults and children which was reviewed in August 2022. There were designated safeguarding leads, with local arrangements and key contacts for making a safeguarding referral. • Senior managers discussed safeguarding at regular monthly meetings. Nurse led meetings were held to discuss vulnerable patients as part of the on-going agenda. Relevant information was recorded in patient records that we sampled. • All staff had received safeguarding training assessed by the practice as being appropriate to their role and this was refreshed when required. • A mixture of clinical and non-clinical staff members had chaperone responsibilities as part of their role. Those staff members had completed relevant training and Disclosure and Barring Service (DBS) checks for clinical staff and risk assessments had been completed for non-clinical staff. • The practice had a system to identify vulnerable patients on record and there were regular discussions between the practice and other community care professionals such as health visitors and social workers where possible. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • At the previous inspection in July 2021, the provider did not have effective systems to ensure oversight of recruitment and staff training was managed appropriately. At this inspection, we saw improvements to the processes relating to recruitment and staff training, with records stored in one system with effective oversight provided by the human resource (HR) manager and practice manager. • There was a recruitment policy in place, which had been updated in January 2022. This included how the practice processed personal data in accordance with the General Data Protection 	

Regulations (GDPR). The practice had maintained records in relation to role specific immunisation for clinical staff.

- The practice had a dedicated induction programme for new GPs and clinical staff including safeguarding protocol, health and safety and fire procedures.
- We carried out recruitment checks in relation to three members of staff which contained all of the required information as per practice policy, including Disclosure and Barring Service (DBS) checks.
- The practice had information about the staff team's hepatitis status and staff were asked on induction about their vaccination history which was kept electronically in individual staff files.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: January 2022	Y
There was a fire procedure. Date of fire risk assessment: January 2022	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • At the previous inspection in July 2021, up to date health and safety risk assessments had not been carried out on the premises to ensure safe working space for staff and environmental risks had been considered for patients. At this inspection, a health and safety risk assessment had been completed in January 2022. This included visitor security, emergency procedures, lone working, hazardous substances and building access. • The practice conducted fire alarm tests weekly, records were maintained to document this. The fire extinguishers had been serviced in May 2022. Staff had completed training relating to fire safety and there were dedicated fire wardens for both locations. • The fire risk assessment conducted deemed the premises compliant. • Portable appliance testing had been completed in June 2022, whilst equipment calibration had been completed in May 2022. • Legionnaire servicing had taken place in April 2022. Records of monthly water checks and flushing records were completed by staff at both locations. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met. Training was not always kept up to date.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: April 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

- The infection prevention and control (IPC) policy was reviewed in March 2022. Standard operating procedures were in place and had been reviewed by the provider IPC lead. The IPC lead was able to demonstrate a comprehensive understanding of infection, prevention and control and their role in ensuring the practice complied with national guidelines.
- Staff were not always up to date with IPC training. We saw evidence of eight members of clinical and non-clinical staff with mandatory modules that had expired and were due for renewal according to the practice's own training policy. Of the eight staff members, three were on long term absence. The provider put an action plan in place and after the inspection, we saw that the outstanding modules had been completed by the remaining staff members.
- The practice had completed an IPC risk assessment, conducted in April 2022. Appropriate measures were in place to ensure the premises was clean and that guidance was available for procedures relating to non-touch technique, hand washing, clinical waste, needlestick injuries and personal protective equipment (PPE). Sufficient information needed to plan safe care was available to staff and patients.

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:

- The practice had five GP partners and 11 salaried GPs providing cover across the two locations. There were three GPs who were on long term absence. The provider had recruited two Advanced Nurse Practitioners (ANPs) who were due to start in October 2022 to assist with providing appointments under the triage model as well as long-term condition clinics.
- There was a recruitment policy for new members of staff with training and guidance for locum and temporary staff. The practice was supported by several additional roles reimbursement scheme (ARRS) staff employed by Heart of Bath.
- There was evidence of staff completing additional training for responding to medical emergencies, for example, sepsis management.
- Staff rotas were completed four weeks ahead of time, with oversight of staffing cover where required. There were adequate clinical staffing arrangements to ensure in the event of emergency, the risk of unsafe practice was mitigated and there was no lone working.

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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none">• There was a dedicated administration team of staff who were responsible for summarising records. We found the practice was up to date with summarising patient records.• The administration team were responsible for ensuring urgent and routine patient referrals were actioned and followed up. For urgent referrals, there was a system for staff to check patients had attended their appointment.• The practice had a 'buddy' system to cover clinician absences for outstanding patient results. However, there was evidence that the task management system did not reflect abnormal patient results that needed to be reviewed on the same day by the cover clinician. There was a risk patients would not receive safe care and treatment in a timely way. The practice had an action plan to revise the system to ensure the 'duty' clinical lead (GP), would provide clinical oversight.	

Appropriate and safe use of medicines

The practice did not always effectively use their 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 PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.67	0.72	0.79	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2021 to 31/03/2022) (NHSBSA)	11.7%	10.0%	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)	4.89	4.79	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	142.2‰	123.0‰	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)	0.98	0.65	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	8.0‰	5.8‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	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.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	No
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:</p> <ul style="list-style-type: none"> At the previous inspection in July 2021, we found systems and processes had not been fully embedded in relation to high-risk medicines. <p>At this inspection we found:</p> <ul style="list-style-type: none"> Clinical supervision was given by the practice's lead GP, providing oversight of performance and nurse prescribing was within scope of practice to ensure safe care and treatment. Discussions were completed at regular intervals but records were not comprehensive to minute these discussions in a high level of detail. Non-medical prescribers we spoke to confirmed they had completed regular prescribing supervision with the clinical lead. The practice operated a Prescription Ordering Direct (POD) service that enabled patients to order their repeat prescription over the phone by trained call handlers using a standard operating procedure. Once the patient had given their consent, the call handler could electronically access the patient's clinical record and process the prescription request in the usual way. Clinical leads and the 'duty' GP were responsible for ensuring safe prescribing including the necessary 	

Medicines management	Y/N/Partial
<p>monitoring and medicine reviews prior to authorisation. Clinical leads were supported by four clinical pharmacists employed by the practice.</p> <ul style="list-style-type: none"> • During this inspection we undertook remote searches of the practice's clinical patient records system to determine whether patients who had been prescribed high-risk medicines had been appropriately monitored and reviewed. We found that: • Newly implemented systems and processes at the time of the previous inspection remained not fully embedded and were insufficient in ensuring patients on high-risk medicines received the appropriate care and treatment. • We identified 2,354 patients who were prescribed Angiotensin-converting enzyme (ACE) inhibitors or Angiotensin II receptor blockers (A2RB), medicines used to treat high blood pressure. Of those patients, 233 had not received the appropriate urea and electrolytes (U+E) blood monitoring for the previous 18 months. There was not sufficient oversight and monitoring of medicines to ensure safe care and treatment was given to patients. The monitoring of patients on high-risk medicines was not always in line with National Institute for Health and Care Excellence (NICE) recommendations. Following the inspection, the provider advised us that 69 patients had blood monitoring that was conducted at the local hospital. Results were unable to be downloaded on the clinical records system. 15 patients were no longer prescribed ACE or A2RB and one declined follow-up. Clinical records were not kept in a way in which provided assurances for safe care and treatment. • We identified 160 patients who were prescribed Potassium sparing diuretics, medicines used to treat high blood pressure or congestive heart failure. Of those patients, 67 had not received the appropriate renal function and electrolyte monitoring for the previous 18 months. There was not sufficient oversight and monitoring of medicines to ensure safe care and treatment was given to patients. The monitoring of patients on high-risk medicines was not always in line with National Institute for Health and Care Excellence (NICE) recommendations. • The practice had a process to manage information changes to a patient's medicines including changes made by other services, for example, the out of hours provider (OOH). • Emergency medicines were stored on a crash trolley, accessible to appropriate staff. There was a stock of medicines within a locked cupboard, with evidence of regular stock checks including a review of expiry dates. Medicines had been risk assessed to ensure appropriate medicines were included. Medical equipment included a defibrillator as well as an oxygen cylinder, with a service agreement for the replacement when oxygen levels were low or expired. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong but safety alerts were not monitored appropriately.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	6
Number of events that required action:	4
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Staff were clear on their roles to raise safety incidents and how to report concerns appropriately.• The practice was able to evidence learning and the dissemination of information relating to significant events. Following a significant event, the practice advised learning from the event was investigated and discussed at quarterly team meetings, where formal minutes were recorded and evidenced.	

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

Event	Specific action taken
An incident occurred where an urgent patient referral was delayed. Correspondence and the referral was scanned to the medical records under the wrong date.	The incident was investigated to find the root cause. The patient was contacted and the duty of candour was applied. The provider updated their administrative procedures to include safety netting within their task management system. Learning had been shared with staff through a significant event meeting to minimise the risk of reoccurrence.
An incident occurred where a patient was administered an incorrectly scheduled vaccine, as per the UK Health Security Agency green book for immunisations.	The incident was investigated to find the root cause. The patient was contacted and the duty of candour was applied. No harm was caused to the patient. The provider revised their immunisation policy to include protocol for clinicians to update patient records at the time of vaccination and consultation to reduce the risk of future incidents. Learning had been shared with staff through a significant event meeting.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	No
Explanation of any answers and additional evidence:	

- At the previous inspection in July 2021, we identified that although the practice had responded satisfactorily to the Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts, there was evidence that not all patients were risk assessed against the sodium valproate alert, published in 2018.

At this inspection we found:

- The provider was unable to provide evidence that there was an effective system to ensure safety alerts were acted upon in a safe way to patients. During our clinical searches, we found 24 patients identified who were prescribed the combination of Clopidogrel, a medicine used to prevent blood clots, and Omeprazole or Ezomeprazole, medicines used to treat acid reflux or protect against stomach ulcers. All of the 24 patients were not informed of the risks associated within the safety alerts and had continued to have been prescribed in combination. This was despite a 2014 MHRA safety alert warning of the risk reduction in efficacy of Clopidogrel when prescribed in this combination.

Effective

Rating: Requires Improvement

We have rated the practice as Requires Improvement for providing effective services because:

- Although there were systems and processes in place for monitoring patients with long-term conditions, these had not yet been embedded in line with evidence-based guidance.
- The practice had not met the minimum NHSE target of cervical cancer screening uptake for eligible patients.

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, but care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	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">• GPs referred patients to secondary care and used two-week pathways where appropriate.• Vulnerable patients were able to access the service during the pandemic. For example, the practice developed COVID-19 "hot" and "cold" clinics at the dedicated locations, logistical clinical areas for patients presented with or without COVID-19 symptoms. Home visit	

appointment triage was available for patients within the local catchment area for those who could not attend the practice and met the criteria.

- Patients were given advice on what to do if their condition deteriorated, for example, call backs or contact with the out of hours service. Communications between the out of hours service was highlighted as effective and proactive when we spoke with senior clinical staff, including the transfer of discharge notifications and changes to patient's prescribed medicine.
- Clinicians employed by the practice had regular appraisals conducted both internally and externally by the local deanery. Evidence was demonstrated to show that clinicians were kept up to date with current guidelines and evidence-based practice.
- The practice did not always use recognised clinical templates effectively which would have ensured best practice guidelines were always followed. Our remote clinical searches showed the monitoring of clinical care was not always clearly recorded. For example, 12 patients were identified as having a potentially missed diagnosis of diabetes. Of the five reviewed, there were shortfalls in coding these correctly, a systematic approach to identify patients who require monitoring upon a clinical search. There was evidence of patients not having completed annual reviews. There were examples where patients had been invited for annual blood monitoring but some declined due to concerns with the COVID-19 pandemic. The provider told us that there were plans in place for further training for clinicians in this area.

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.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed 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 supported six residential and nursing homes.
- The practice employed a clinician to carry out urgent appointments for older and shielding patients who were unable to attend the practice.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- 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.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- At the previous inspection in July 2021, we found systems and processes for monitoring patients with long-term conditions were not always operating effectively.
- At this inspection we found, patients with long-term conditions were not always offered a structured annual review to check their health and medicines needs were being met. We identified issues with patient medicine reviews and the process for outstanding monitoring of long-term conditions. For example:
- We identified 87 patients with chronic kidney disease (CKD) stage 3, 4 or 5, of which 20 patients did not have the appropriate including blood monitoring, urea and electrolytes (U&E) or blood pressure recorded within the last nine months. There was evidence of some patients receiving a consultation review within this timeframe, but not all aspects of the appropriate monitoring were completed. Following the inspection, the provider advised us that some of these patients either declined follow-up or were under monitoring by the local hospital. For those patients who had monitoring at the local hospital, prescriptions were managed by the practice. Clinical records were not kept in a way in which provided assurances for safe care and treatment.
- We identified 915 patients with hypothyroidism, a condition which results in low activity of the thyroid gland. Of those, 67 patients had not received the appropriate thyroid function (TFT/TSH) blood monitoring within the last 18 months.
- The remote searches that we undertook of the practice's clinical patient records system showed that there was a lack of oversight of long-term condition management to ensure safe care and treatment was given to patients. The monitoring of patients with long-term conditions were not always followed in line with National Institute for Health and Care Excellence (NICE) recommendations. The provider had active recruitment with two Advanced Nurse Practitioners (ANPs) starting employment in October 2022 to provide support in this area.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	219	229	95.6%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	210	226	92.9%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for	210	226	92.9%	Met 90% minimum

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)				
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)	209	226	92.5%	Met 90% minimum
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)	205	231	88.7%	Below 90% minimum

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

Any additional evidence or comments

- Clinical staff we spoke with were aware of the practice's initiative to provide further education to assist young families in the importance of these immunisations.
- The practice monitored Did Not Attend (DNA) appointments with appropriate follow-up processes to ensure children were safeguarded from potential abuse or neglect.
- Staff had the appropriate skills and training to carry out reviews for this population group. Staff had access to annual immunisation updates and followed the NHS green book, which sets out immunisation schedules, patient information and contraindications.

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)	69.4%	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)	65.8%	67.4%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	65.0%	69.9%	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)	65.6%	62.3%	55.4%	No statistical variation

Any additional evidence or comments

- The practice did not meet the minimum 80% target of eligible patient uptake of cervical screening. The practice were aware of this and were working to improve it. However, due to the recent departure of two experienced practice nurses, the training process of practice nurses to be qualified in performing cervical screening was affecting the practice's ability to address this gap quickly. The practice had identified the staff eligible to do the training and was providing opportunities to shadow experienced staff to learn the procedure in preparation for their training commencing. The practice had an action in place to improve the uptake of cervical screening for patients, including the review of all eligible patients and whether or not they were still registered at the practice.
- The provider combined female health appointments with other acute or routine patient needs where possible. At the time of inspection, female health clinic appointments were available to book in advance.
- The practice had a proactive system to manage two week wait referrals, for any patients with suspected cancer. We saw evidence that this was up to date.

Monitoring care and treatment

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

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

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

<p>The clinical staff had carried out a range of audits, this included:</p> <ul style="list-style-type: none">• An audit to check patients who had diagnosis of dementia were correctly coded and diagnosed to facilitate appropriate monitoring and support for this patient group.• The pharmacists had an audit schedule for 2021 to ensure safe prescribing.• An audit of patients on insulin without a diagnosis of diabetes showed three patients were identified who had had diabetes in pregnancy, which had now resolved. This demonstrated patients were appropriately monitored and subsequently coded as pre-diabetic. These patients were continually monitored, as recommended, in line with national guidelines.• The pharmacy team had completed a prescribing safety audit of medicines, with schedules set across 2021 and 2022. This detailed actions as tasks set to review patient monitoring including blood monitoring and structured medicine reviews.

Any additional evidence or comments
<ul style="list-style-type: none">• The provider, Heart of Bath, had an active clinical research unit, run by a clinical research nurse and study coordinator and supported by a core research team which included two of the GP Partners. In addition, all staff were encouraged to take part in and promote research to patients. Heart of Bath was currently involved in over 20 research studies, working closely with the National Institute of Health Research (NIHR) and universities. Since March 2020 they had focused on supporting Urgent Public Health Research, such as the Principal Trial, Virus Watch and surveys to understand the psychological response to the Covid-19 pandemic. In 2021, over 1,000 patients participated in research studies delivered by Heart of Bath, potentially giving them access to innovative treatments.

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.	Partial
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">• At the previous inspection in July 2021, there was evidence of non completion of mandatory training modules by staff and the management and oversight of this was held in different locations resulting in an ineffective system.• At this inspection:• We saw improvements to the way staff training, appraisals and HR records were managed. There was a system for staff to complete training online. However, there was evidence that mandatory training had not been completed by all staff members that were essential to their roles. For example, incomplete modules such as safeguarding children and vulnerable adults as well as infection prevention and control (IPC) and basic life support. After the inspection, the provider showed us evidence that this had been completed by all staff members. The provider had plans in place to reintroduce face to face basic life support training in light of COVID-19 restrictions easing.• We observed records which verified appraisals were conducted with staff, performance monitored and objectives set. Staff were supported to meet the requirements of professional revalidation, including registrations with the General Medical Council (GMC) and Nurse Midwifery Council (NMC), where appropriate.• There was a recruitment policy which outlined the process for new starters. Induction checklists were in place for new staff members for probationary review. Induction guidance was available for locum and temporary staff.	

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> <p>The practice had a system to manage communication between services about patients so that they received consistent and co-ordinated care. For example, meetings took place between the local Out of Hours service and the provider for the safe handover of clinical records and treatment plans of patients moving between the services. The practice used a task management system which clinicians to raise specific clinical tasks with the lead GP outside of the set daily meeting as a safety mechanism.</p>	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice employed a social prescriber who signposted patients to community sources of support. 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 three care homes allocated with nurses employed to provide care for residents. Daily home visit appointments were available to those patients that were vulnerable and high risk. 	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• During a review of clinical records, we identified that consent and decision making was recorded in line with legislation and guidance.• We reviewed three patients with a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) record to consider whether the DNACPR had been prepared and agreed appropriately. The records were signed and authorised with the latest reviews within the required 12 month date. Recommended Summary Plan for Emergency Care and Treatment (RESPECT) forms were used for end of life patients where appropriate.	

Responsive

Rating: Not rated

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 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 prioritized	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y

Well-led

Rating: Requires Improvement

We have rated the practice as Requires Improvement for providing Well-led services because:

- Some of the systems and processes continued to require further improvements to provide the leadership team with assurances and oversight of the quality of care.

Leadership capacity and capability

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.	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:

- During the pandemic, the leadership team had responded to challenges by implementing provisions for the local COVID-19 vaccination program for over 28,000 patients. They were solely responsible for providing staff and seconded up to three GPs, two pharmacists and approximately half of the nursing and administration team from December 2020 to July 2021 for seven days a week from 8am to 8pm. This had impacted the embedding of systems and processes introduced at the partnership across both locations.
- At the last inspection, the practice had failed to complete health and safety risk assessments for the premises at both sites. This had been completed at this inspection alongside updated policies and procedures linked with providing oversight for the management of care and treatment.
- The practice had oversight of a succession plan which included leadership development, career progression and plan to replace future staff leavers. However, there was no review date to suggest when this had been completed and if staff could access the document.
- We received 20 staff questionnaires and spoke with different members of staff both during online interviews and during the site visit to the practice. We observed themes which included improved communication by the leadership team that reflected any changes to the service. However, staff felt there was a challenge to actively recruit clinical staff to ensure there was adequate capacity to meet patient demand.
- Staff feedback was obtained annually, staff felt that leaders visible and approachable.

Vision and strategy

The practice had a clear vision and credible strategy, but new measures had not yet been fully embedded.

	Y/N/Partial
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The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a mission statement displayed on the practice's website which staff told us they knew about. Staff told us they were proud to work for the practice, albeit there were challenges placed with workload due to reduced staffing numbers. • The lead partner and the practice manager had a vision for the practice to have a strong leadership which promoted improvement for staff and patients. • There was a business strategy and improvement plan in place. This included plans for future logistics to the service locations; strategies to improve clinical space through leasing agreements; the reintroduction to carers clinics; as well as patient access through additional parking spaces. Each target was continually monitored by the leadership team. Dates were recorded against the objective where possible. • The provider had a set of values developed with staff to support the overall mission statement. 	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At the previous inspection in July 2021, the practice did not have a freedom to speak up guardian in place but encouraged an 'open door' policy. At this inspection, this had now been implemented. Staff also had access to a mental health first aider. There was a whistleblowing policy in place. Staff reported culture had improved as staff had risen to the challenges of working during the pandemic and since the commencement of the practice manager. Equality and diversity training was deemed by the practice as mandatory for all staff. There was evidence that three members of staff had not completed this module at the time of inspection. Two of which were on long term absence and were not expected to have kept up to date whilst not working at the practice. After the inspection, we saw evidence that this training had been completed and was up to date. 	

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

Source	Feedback
20 staff CQC feedback forms	<p>Common themes included:</p> <ul style="list-style-type: none"> Staff were friendly and supportive. Actions were responded to swiftly. More clinical staff were required to meet patient demand, workload was challenging. There were visions to drive service improvement and to share all standardised processes across both locations. Practice management needed time to embed governance arrangements.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support management decisions. However, governance arrangements were not fully embedded.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Governance structures were not always in place to provide well-led services which were regularly reviewed. At our previous inspection, we noted that newly implemented systems and processes needed time to embed. However, at this inspection, we found that these were still not fully implemented and there were shortfalls in oversight of some areas. For example, the practice protocol for reviews for patients with long-term conditions were not always effective to ensure safe care and treatment. There were not enough suitably trained staff or clinical support by current staff to ensure these processes were undertaken in line with national guidance. The practice had an action plan to review medicine management procedures and criteria for patient medicine reviews subsequent to inspection findings. • The practice had a clinical team led by five GP partners. There were a lack of governance arrangements to ensure the registered manager was supported in delivering strategies to ensure safe and effective care and treatment was provided. • Clinical supervision of nurse prescribing was provided by the lead GP to ensure staff were providing care within scope of practice. Informal conversations were completed at regular intervals but records were not comprehensive to minute these discussions. There were a lack of documented clinical notes audits, qualitative notes records and appropriate care plan reviews minuted and completed which would have provided evidence for staff competency and medical revalidation for the continuation of clinicians licence to practice. Non-medical prescribers we spoke to confirmed they had completed regular prescribing supervision with the clinical lead. 	

Managing risks, issues and performance

There were 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.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
We saw some examples where risks, issues and performance were managed, these included:	
<ul style="list-style-type: none">• A quality improvement audit program was in place, which was reviewed by the practice management team.• A business continuity plan was in place which gave guidance to staff for the preparation of major incidents. Impact of care was assessed and involved external stakeholders, for example, the local care homes attached to the practice.• The practice had a system in place to liaise with specialists when looking at patient management for specific conditions such as dermatology or musculoskeletal (MSK) conditions.• There was a system in place and clear lines of accountability for the supervision and appraisal of staff. There were opportunities for staff to undertake continuous professional development (CPD).• The lead partner and the practice manager met weekly to review performance and risks. In addition, all partners met on a monthly basis.	
However, we found the practice did not have embedded systems and processes in place to assess the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks.	
<ul style="list-style-type: none">• Care pathways and protocols evidenced within records for patient prescribed high-risk medicines were not always followed in line with national guidance.• There was evidence that the process for managing patient safety alerts was not always followed appropriately to ensure patients were protected from harm. Including the management of Medicines & Healthcare products Regulatory Agency (MHRA) alerts to demonstrate safe practice.	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice commented that improvements had been made in relation to access since the pandemic, there was an ongoing full team effort in improving access and working with patients to make the practice more accessible. • During the pandemic, the practice changed the way that patients could access services, such as providing remote video consultation. Home visit appointment triage was available for patients within the local catchment area for those who could not attend the practice and met the criteria. • Vulnerable patients were able to access the service in ways that their needs during the pandemic. For example, with the development of COVID-19 'hot' and 'cold' clinics, logistical clinical areas for patients that presented with or without COVID-19 symptoms. • Provisions for infection control arrangements were in place for staff and patients during the pandemic, for example, personal protective equipment (PPE). • All staff were offered to work from home during the pandemic where possible, and the practice supplied laptops. • Staff were supported to isolate as per government guidelines to help protect staff, patients and the wider general public. 	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice had not needed to make any statutory notifications to relevant organisations such as the Care Quality Commission (CQC) or National Health Service England (NHSE) within the last 12 months. However, members of the leadership team were aware of their responsibilities to do so if a notification was required.	

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">The provider had a registered data controller and data protection officer.Patient data and information was stored securely in line with digital security standards with relevant information was made available for patients to access in line with privacy, consent notices and general data protection regulations.	

- Information was available for patients on how their data was used, choices regarding consent and how to protect their online data through notices within the practice, practice registration forms or online via the practice website.

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice had an employer's handbook that provided information regarding human resources, whistleblowing, salary and entitlements. Staff told us that staff meetings had better attendance because they were online. Meeting minutes were available for staff who could not attend. The leadership team explained that communication regarding service updates was delivered through the weekly bulletin which was sent to all staff. Staff were able to give feedback through regular service meetings or at annual appraisals. 	

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> The patient participation group (PPG) met with provider leaders quarterly. The PPG held preparatory meetings with its' 25 members hosted online to address updates and themes amongst the practice patient population. Common themes identified reported included patient care was high quality despite access issues. Online patient resources and access could be improved such as updated patient service information. A further suggestion included the drive to improve patient education on the usage of online services including access. However, the dedicated patient email mailbox was a welcomed addition. Active recruitment was in place for clinical staffing, this challenge was not specific to this practice and has been recognised as a national difficulty. There had been noticeable improvements since the Heart of Bath provider merger included the engagement with the PPG.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The provider also offered a CQC registered service at another location, which was a service for homeless people. The nursing team, with clinical oversight of a dedicated GP lead, saw patients on site and would also carry out outreach work to engage with other patients who did not attend the centre.• The practice was an approved training practice with allocated GP trainers. Placements were provided each year for doctors training to be GPs (GP registrars). Clinical education meetings were held regularly where learning and improvement was discussed.	

Examples of continuous learning and improvement

- Heart of Bath had an active clinical research unit, run day to day by a clinical research nurse and study coordinator supported by a core research team that included two GP Partners. In addition, all staff were encouraged to take part in and promote research for patients.

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.