

Inspection Evidence Table

London Street Surgery

(1-8027115380)

Inspection Date: 6 December 2022

Date of data download: 22/11/2022

Overall rating:

Requires improvement

At the previous comprehensive inspection in April 2022, we rated the practice as inadequate overall and the practice was placed into special measures. The reasons for this rating were:

- The provider was failing to assess, monitor and improve the quality and safety of services as the systems that were in place were not appropriate to ensure the health, safety and welfare of patients and staff.
- The provider was failing to provide care in a safe way to patients as they were not assessing the risks to the health and safety of service users in receiving care or treatment or doing all that is reasonably practicable to mitigate any such risks.

We completed a focused inspection in September 2022 to follow up on the high risk concerns we identified at the inspection in April 2022 and saw improvements had been made on the previous breaches of regulations. No rating was provided at the September 2022 inspection.

Despite the improvements made since April 2022 we have rated the practice Requires improvement overall because:

- The provider was not effectively providing care in a safe way to patients as they were not always assessing the risks to the health and safety of service users in receiving care or treatment or doing all that is reasonably practicable to mitigate any such risks.
- Governance processes were not fully implemented or embedded to assure leaders of the quality and safety of systems and processes and to identify where quality improvements may be needed.

Safe

Rating: Requires improvement

At the previous comprehensive inspection in April 2022, we rated the practice as inadequate for providing safe services because:

- There was poor identification of risks to patients.
- Repeat prescribing and medicines were not managed safely, posing a risk of harm to patients.
- There were significant backlogs of test results and care-related tasks.
- There were risks associated with the storage of blank prescriptions.

At the focused inspection in September 2022, we found the practice had improvements however, we found:

- Medicine reviews did not always contain documented outcomes of the review and decisions made.
- Monitoring test results received by the practice were not always checked prior to prescribing to ensure it was safe to continue to prescribe.

At this inspection in December 2022, we have rated the practice as Requires improvement for providing safe services because:

- The practice did not have an effective system to ensure staff had received the appropriate vaccinations to keep themselves and patients safe.
- Patients were not always informed of safety alerts in a timely manner which may increase their risks.
- Patient Specific Directions were not in place for staff giving vaccines where required.
- Prescription stationery security was not sufficient.

Safety systems and processes

The practice had clear systems to safeguarded people from abuse however, processes and systems did not always reduce risks that had been identified to keep people safe.

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: At the last inspection in April 2022, we found the provider had not ensured safeguarding training was at the appropriate level for all clinical staff . Staff also told us that non-English speakers were on occasion encouraged	

by staff to attend with English-speaking friends or relatives to act as translators during appointments with clinicians. There was a risk that patients may have consultations without the ability to disclose personal information or other concerns to clinicians, such as reporting abuse.

At the focused inspection in September 2022, we found the provider had assessed each role against current intercollegiate safeguarding guidance. The provider was aware only 1 member of staff remained to complete the appropriate training for their role and following this inspection, the training was completed.

At the focused inspection in September 2022, we found the provider had implemented a system to support non-English speaking patients with telephone or face to face options available. The provider stated in an emergency, they would still allow a family member or friend to support the patient with translating and were aware of the associated risks to spot such as signs of abuse and coercion and control.

At this inspection in December 2022, we found all staff had completed safeguarding training in line with intercollegiate safeguarding guidance.

We viewed 2 recruitment files for staff that had started at the practice since the last inspection and both files contained evidence of DBS checks. However, we found there had been a DBS check applied for in relation to a member of staff at the practice and that member of staff was not allowed to work alone until the DBS check had been received. The DBS policy did not refer to this process and we did not see a risk assessment in place that identified and mitigated risks relating to this member of staff working before the DBS check result was received.

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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in April 2022, we found the practice did not have a system in place to ensure clinical staff had appropriate vaccinations to undertake their roles safely.</p> <p>At this inspection in December 2022, we found the practice had emailed staff to ask them when they had received Hepatitis B, COVID-19 and flu vaccinations but did not routinely request evidence to assure themselves staff were appropriately vaccinated. The practice's record of staff vaccinations did not include all relevant vaccinations in line with current UK Health Security Guidance. However, we did see evidence of a full vaccination record in 1 of the 3 staff files viewed. Staff without the appropriate vaccinations who had direct contact with patients therefore posed a risk to patients. The practice had not ensured staff were up to date with all appropriate vaccines in line with national guidance.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Partial
Date of last assessment: Various, October 2022	

There was a fire procedure.	Yes
Date of fire risk assessment: March 2022	
Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in April 2022, we found a fire risk assessment had taken place just prior to the inspection and it had identified the need for a 5-year electrical safety check and there was a plan in place to get this completed.</p> <p>At this inspection in December 2022, we found the practice had an external company complete a health and safety audit in October 2022 which included risk assessments such as workplace safety, electrical safety and disability access. The audit identified issues that needed immediate action which included the need for a 5-year electrical safety check that still had not taken place. However, the action plan did not always thoroughly address each issue that was identified. For example, it identified a sufficient number of evacuation chairs needed to be provided for the site and the practice had noted they were obtaining quotes. This action was rated as high and there was no further update since it was identified in October 2022. Following the inspection, the practice told us they had received quotes for the work and were in discussions with the property owners.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit: October 2022	
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in April 2022, we found some non-clinical staff were not fully aware of the process or training on how to receive specimen samples when patients returned them to the reception desk.</p> <p>At this inspection in December 2022, we found staff we spoke to were fully aware of the processes for receiving specimen samples from patients.</p> <p>An infection prevention and control audit was carried out in October 2022 by the infection, prevention control lead for the local Integrated Care Board. The audit identified areas for improvement and some actions that were required but we saw no evidence of actions being completed or a timescale of when they would be completed. For example, the audit identified it was not clear if the vaccine fridge was serviced on a regular basis in line with the manufacturer's instructions. This was noted as being investigated in November 2022 but there was no further update or action recorded by the time this inspection took place in December 2022, 2 months after the audit. The infection prevention control lead for the practice was a non-clinician who had only</p>	

completed training in non-clinical infection prevention and control. They were supported by a clinician that had completed clinical training in infection prevention and control but there was no record to evidence either had completed the appropriate training to lead in this area.

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
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in April 2022, we found reception staff had completed training in identifying sepsis but had not received training or have access to guidance in how to identify or respond to patients with high risk symptoms such as chest pain.</p> <p>At the focused inspection in September 2022, we found all non-clinical staff had completed training in health navigation to identify patient symptoms and support them to access the appropriate service.</p> <p>At this inspection in December 2022, we spoke to staff who confirmed they knew how to respond to medical emergencies and had access to guidance on identifying patients with high risk symptoms.</p>	

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	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
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in April 2022, staff did not have the information they needed to deliver safe care and treatment. Our remote searches of the clinical patient records system identified significant risks in the provider's approach to the management of test results which had created a backlog of correspondence that had not been reviewed or actioned.</p> <p>At the focused inspection in September 2022, we found the practice had implemented a system for the administration team to manage correspondence. However, there was no documented policy for this process.</p> <p>At this inspection in December 2022, we reviewed a pathology results policy the practice had implemented which documents how the practice manages test results. All test results were reviewed by clinicians. We reviewed the test results that had arrived on the practice's electronic patient record system and found they were being dealt with in a timely manner.</p>	

Appropriate and safe use of medicines

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

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) <small>(NHSBSA)</small>	0.64	0.73	0.82	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). (01/10/2021 to 30/09/2022) <small>(NHSBSA)</small>	3.7%	8.8%	8.5%	Variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	5.25	5.52	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	85.8‰	87.4‰	128.0‰	No statistical variation

Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHSBSA)	0.23	0.43	0.58	Variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	6.4‰	6.3‰	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).	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.	Yes**
There was a process for the safe handling of requests for repeat medicines and evidence of effective 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. 2	Yes
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.	Yes
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

Explanation of any answers and additional evidence, including from clinical searches.

*At the last inspection in April 2022, we found there was no process to ensure the secure storage of blank prescription stationary.

At the focused inspection in September 2022, we found the practice had implemented a new system to ensure prescription stationary was being stored securely.

At this inspection in December 2022, we found the main store of blank prescription stationary was secure. However, blank prescriptions were not tracked through the practice and it was unclear who had taken a blank prescription. A small number of blank prescriptions were removed from the main store and placed in reception in a lockable cupboard. The key for this cupboard was stored next to the cupboard and it was accessible to anyone who entered the reception area, including cleaning staff who had access when other staff had left the building. The reference numbers for these blank prescriptions were recorded when they were taken from the main store. There was no way to track who had taken each prescription when removed from the cupboard in reception by clinical staff. This meant there may be a risk of removal by non-authorized staff and the practice would not be aware. Following this inspection, the practice told us they will record who has taken a blank prescription from the cupboard in reception which will be locked and 1 of the GPs will be keep the key safe.

At this inspection in December 2022, we found appropriate Patient Group Directions (PGD) were in place. A PGD is a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. However, Patient Specific Directions were not in place to authorise non-clinical staff to give vaccines. A PSD is a written instruction, from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis. Following this inspection, the practice told us they would not hold another clinic with non-clinical staff until they had completed PSDs where required and these would be saved on the patient's electronic record.

**Staff told us that they regularly spoke to the lead GP and had their work and competence reviewed however, this was done verbally and there was no written record to evidence this had taken place.

At the last inspection in April 2022, our remote clinical searches identified patients on high risk medicines were not receiving appropriate reviews to ensure they were safe to continue with their prescribed medicines.

At the focused inspection in September 2022, we found the medicine reviews had taken place but were not fully documented in the patient's clinical record.

At this inspection in December 2022, we found patients had received appropriate reviews. For example, we found all 15 patients that have been prescribed Methotrexate had received the appropriate monitoring. (Methotrexate is a type of medicine used to treat inflammatory conditions). However, our searches found the reason this medicine had been prescribed was not always documented in the electronic patient records. This medicine is taken once a week and the electronic patient records did not state what day of the week the patient is to take the medicine to reduce the risk of a fatal overdose. Following the inspection, the practice told us they had added the reason for the medicine to the electronic patient records and contacted all these patients to find out when they take their medicine and added this to their electronic patient record.

At the last inspection in April 2022, we found there was only 1 thermometer in the vaccine fridge which meant there was no secondary verification of temperature readings, in line with national best practice guidance.

At this inspection in December 2022, we found there to be a data logger in place as well as the thermometer to verify temperature readings.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong however, the process for informing patients of safety alerts was not always effective.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
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:	8
Number of events that required action:	8
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in April 2022, we found the practice was not effectively using external information such as medicine alerts to identify risks to patients.</p> <p>At this inspection in December 2022, we found the practice did not have an effective process to monitor and review medicine safety alerts to identify and notify patients of risks (see Safety alerts section below).</p> <p>*Staff told us they would raise concerns internally with the lead GP or practice manager however, at the time of the inspection, there was no Freedom to Speak Up Guardian to support staff to raise concerns externally to the practice. (Freedom to Speak Up Guardians support workers to speak up when they feel they are unable to do so. Their role should be independent and impartial, and they should abide by the guidance from the National Guardian's Office). Following the inspection, a Freedom to Speak Up Guardian was identified and their contact details were shared with staff.</p>	

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

Event	Specific action taken
A patient's wife had requested a call back as the patient was feeling unwell. The patient deteriorated and patient's wife phoned back to say he was very unwell.	The GP made a phone call as soon as they could. The practice reiterated to staff they were to pass on messages more quickly.
Electronic documents were being filed incorrectly when they were received by the practice.	The electronic system was to be checked daily. The event was discussed at a team meeting on the same day to highlight the issue with the team.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection in April 2022, we found medicine safety alerts were not always acted on appropriately.</p> <p>At the focused follow up inspection in October 2022, we found the practice had implemented a system to receive safety alerts from the Medicines and Healthcare products Regulatory Agency (MHRA) and acted in response by running searches of their clinical system to identify and review the risk to any affected patients.</p> <p>At this inspection in December 2022, we found the system to follow when an alert was received by the practice was not always effective as there was sometimes a delay between the practice receiving the alert and notifying patients. For example, we identified 18 patients that were prescribed teratogenic drugs (medicines that may increase the risk of birth defects during pregnancy). Patients of childbearing age prescribed these medicines should have a pregnancy prevention plan or annual risk assessment in place. We reviewed 5 of these patient records and although we saw evidence 2 of these patients had been informed of the risks, 4 of these patients did not have pregnancy prevention plans or annual risk assessments completed. Patients had not always been informed of the risks in a timely manner to when safety alerts had been issued. For example, in April 2022, a patient safety alert regarding pregnancy and pregabalin (a medicine used to treat conditions including epilepsy, anxiety and nerve pain) was issued by the Medicines and Healthcare products Regulatory Agency. We reviewed the records of 3 patients prescribed this medicine who were of childbearing age and saw no record of a discussion around this safety alert for 2 of these patients, A voicemail had been left for the third patient in November 2022 This did not provide assurance staff always understood the urgency of the alerts or that there was a robust system in place to ensure patients were informed of any risks associated with the medicines they have been prescribed as soon as possible.</p>	

Effective

Rating: Requires improvement

At the previous comprehensive inspection in April 2022, we rated the practice as Requires improvement for providing effective services because:

- Some patients with long term conditions were not having their conditions managed appropriately.
- Patients with learning disabilities were not provided with health checks to ensure their wellbeing was being monitored.
- Staff training was not monitored appropriately.

At the focused inspection in September 2022, we saw the practice had made improvements in staff training and the completion of health checks for patients with learning disabilities. However, we found:

- Patients with long term conditions had not received routine monitoring tests and diagnoses were not always recorded accurately.

At this inspection in December 2022, we have rated the practice Requires improvement for providing effective services. We found the practice had made improvements in reviewing and monitoring patients and the care coordinator was working to ensure patients with a learning disability were invited for their annual health checks. However, we also found:

- The practice did not have an effective process in place to encourage eligible patients to attend cervical screening appointments.
- The practice did not have a programme of learning and development for staff.
- Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were not recorded accurately and were not reviewed.

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. ¹	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	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
The practice prioritised care for their most clinically vulnerable patients	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection in April 2022, we found patients did not always receive information or a review of their long-term condition.</p> <p>At this inspection in December 2022, we found systems had been implemented to ensure patients with long term conditions were fully assessed, monitored and reviewed when required.</p>	

Effective care for the practice population

Findings
<ul style="list-style-type: none"> • The practice identified older patients who were living with moderate or severe frailty. • Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group. • All patients with a learning disability were offered an annual health check. • End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. • The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule. • The practice demonstrated that they had a system to identify people who misused substances. • The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder • Patients with poor mental health, including dementia, were referred to appropriate services. <p>At the last inspection in April 2022, we found 6 of the 26 patients with a learning disability had their annual health check completed over the previous 13 months. The practice told us that in the future, a care coordinator would carry out these reviews.</p> <p>At the focused inspection in September 2022, we found 16 of the 26 annual health checks had been completed for patients with a learning disability by the care coordinator and there was monitoring of the outstanding reviews. The care coordinator was contacting patients daily to support them to get their annual health checks.</p> <p>At this inspection in December 2022, the care coordinator told us 20 of the 26 annual health checks for patients with a learning disability had been completed and was continuing to contact patients to ensure they were completed.</p>

Management of people with long term conditions

Findings

- Patients with long term conditions were offered an effective annual review to check their health and medicines needs were being met.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Patients with Chronic Obstructive Pulmonary Disease were offered rescue packs.

At the last inspection in April 2022, we reviewed 5 patient records who had a potential missed diagnosis of diabetes. All 5 patients were confirmed as diabetic, but they had not been coded correctly. At the focused inspection in September 2022, we did not identify any patients that had a potential missed diagnosis of diabetes.

At this inspection in December 2022, our clinical searches identified 1 patient that had the potential for a missed diagnosis of diabetes, however, they also had other health conditions that would affect the test results used to diagnose diabetes and the practice were aware of this.

At the last inspection in April 2022, our clinical searches identified 41 patients with hypothyroidism had not received appropriate monitoring or review. At the focused inspection in September 2022, we found 2 patients had not had the appropriate monitoring or review.

At this inspection in December 2022, we identified all 127 patients diagnosed with hypothyroidism had received appropriate monitoring and review within the last 18 months.

At the focused inspection in September 2022, our clinical searches identified 3 of the 221 patients on the asthma register had been prescribed 2 or more courses of rescue steroids. All 3 had received medication reviews in the previous 12 months and we were assured the risk to these patients of uncontrolled asthma was low.

At this inspection in December 2022, our clinical searches identified 3 of the 222 patients on the asthma register had been prescribed 2 or more courses of rescue steroids in the previous 12 months. One of these patients was under secondary care for their respiratory conditions however, the practice had not carried out an adequate annual asthma review since 2015. One of these patients had a partial asthma review carried out over the phone, however, still required a full asthma annual review and the other patient needed to have a steroid card issued.

At the focused inspection in September 2022, we identified 41 patients had a potential missed diagnosis of chronic kidney disease stages 3,4 or 5. We reviewed 5 of these patient records and found all 5 had confirmed to have chronic kidney disease but had not been informed of the diagnosis. The practice told us they had reviewed all the identified patients and reviewed their diagnosis and coding.

At this inspection in December 2022, our clinical searches did not identify any patients with a potential missed diagnosis of chronic kidney disease stages 3,4 or 5.

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)	53	58	91.4%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021))(NHS England and Improvement)	49	52	94.2%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021))(NHS England and Improvement)	49	52	94.2%	Met 90% minimum
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)	50	52	96.2%	Met 95% WHO based target
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)	52	58	89.7%	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>

Cancer Indicators	Practice	SICBL average	England	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). (30/06/2022 to 30/06/2022))(UKHSA)	53.6%	N/A	80.0%	Below 70% uptake
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)	28.6%	51.9%	55.4%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021))(UKHSA)	63.1%	70.9%	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)	56.0%	67.9%	66.8%	N/A

Any additional evidence or comments

At the last inspection in April 2022, the practice gave us unverified data that showed 51% of 25-49 year olds and 70% of 50-74 year olds were screened adequately within a specified period.

At this inspection in December 2022, the practice gave us unverified data that indicated an increase in the uptake of cervical screening. The practice told us 53% of 25-49 year olds and 71% of 50-74 year olds were screened adequately within a specified period.

The practice told us patients were invited for their cervical screening by secondary care. The practice told us they had a very diverse patient population with some hard to reach patients however, they followed up with inviting patients to attend appointments and offer appointments on occasional Saturdays.

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

	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.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past 2 years:</p> <p>At the last inspection in April 2022, we found audits on clinical care and treatment were ineffective in identifying improvements.</p> <p>At the focused inspection in September 2022, we were given an example of an audit however, the practice was unable to demonstrate if it had improved patient care because the audit did not include the practice's initial baseline performance for comparison.</p> <p>At this inspection in December 2022, we saw some clinical audits had taken place to improve the quality of care and treatment and the practice had taken part in a local quality improvement initiative. However, the practice had yet to implement a full programme of targeted audits to review and improve their service.</p> <p>We were given an example of an audit looking at the compliance with guidelines when prescribing antibiotics to patients over 65 was completed in November 2022. The audit identified some actions and learning points and that an action plan was be put in place. At the time of this inspection, the action plan had not been implemented.</p>	

Any additional evidence or comments

A long-term locum GP told us they had completed an audit on patients with hypothyroidism for their annual appraisal however, the practice was not aware of this audit so was unable to use this information as part of their clinical governance.

Effective staffing

The practice was able to demonstrate 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.	Partial*
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
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in April 2022, we found the practice did not have a full oversight of staff training as some staff had not completed appropriate training for their role and there was no training record for 1 member of staff.</p> <p>At the focused inspection in September 2022, we found improvements had been made to staff training and there was a training record for each staff member.</p> <p>*At this inspection in December 2022, we found the practice had a system to monitor training for all staff. We found staff were up to date with nearly all their mandatory training. However, there was no system to identify the training required by staff. For example, the infection control lead who was in a non-clinical role at the practice had not undertaken an adequate level of training to undertake their lead role, there was no evidence staff carrying out spirometry (a method of assessing lung function) had completed training in that area and not all staff had completed training in equality and diversity.</p>	

Coordinating care and treatment

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

	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 last inspection in April 2022, we found there was a lack of monitoring regarding patient correspondence which may be a risk to patient care. At the focused inspection in September 2022, we found the practice had implemented a new system to manage and monitor correspondence that was received from external sources. At this inspection in December 2022, we found this system to be working effectively and saw no backlog of documents awaiting review.	

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 was unable to demonstrate that it 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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Partial
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	No
<p>Explanation of any answers and additional evidence:</p> <p>The practice had 9 patients with a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decision in place. We reviewed 3 DNACPR paper forms that the practice had completed. The forms had not been completed fully and therefore, were not an accurate reflection of the decision made. For example, 1 of the paper forms recorded a decision made in 2015 which not been reviewed since then, not all sections of this form had been fully completed and it had not been signed by the GP. The remaining 6 DNACPR decisions had been completed by secondary care but the practice did not have a copy. We reviewed 1 of these clinical patient records and found the practice had received a letter from secondary care to confirm a DNACPR decision had been recorded but the practice had not requested or reviewed the decision. Following the inspection, the practice told us they had arranged to review the 3 DNACPR paper forms.</p>	

Responsive

Rating: not inspected

Access to the service

People were able to access care and treatment in a timely way.

	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 (including those who might be digitally excluded).	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: The practice told us they had recently reviewed their appointment booking system and had implemented changes. Patients called the practice to make an appointment with the GP – some appointments would be offered face to face and some would be offered as an initial phone call and then possibly followed with a face to face appointment if required. If a patient requested a face to face appointment, it would be offered wherever possible. All patients aged 2 and below would be offered a face to face appointment straight away. The practice did not offer e-consult appointments, but they told us this was something they were looking into. *The practice was open on occasional Saturdays to offer services such as cervical screening and vaccinations however, this was not detailed on their website.	

Well-led

Rating: Requires improvement

At the previous comprehensive inspection in April 2022, we rated the practice as inadequate for providing well-led services because:

- There was limited independent quality improvement on the part of the practice and leaders did not have sufficient audit and monitoring processes to ensure the safety and effectiveness of services.
- There was insufficient capacity to ensure appropriate governance systems were in place, particularly clinical governance.

At the focused inspection in September 2022, we saw the practice had made improvements however:

- Some governance processes had changed but were not fully embedded.

At this inspection in December 2022, we found improvements had continued however:

- Quality assurance processes were not always effective in identifying issues and improving services.
- Governance systems and processes were not always effective.
- The system for the management of risks was not always effective.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels that understood the requirements to deliver high quality sustainable care however, the systems in place did not always identify and carry out actions required.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: At the last inspection in April 2022, we found the COVID-19 pandemic had affected staffing at the practice which had impacted the delivery and oversight of care. At the focused inspection in September 2022, we found the practice was actively working towards reforming a partnership to increase leadership, management and practice oversight. Correspondence was being regularly monitored and searches were being routinely carried out. However, the systems and processes to identify patients that required monitoring tests and reviews had not been fully embedded and we saw examples of where patient care did not follow national guidance. At this inspection in December 2022, we found the new practice manager was well established in their role, there were 4 long term locum GPs and further staff had been recruited to support the practice. Clinical leadership had improved <u>improved</u> , and systems had been implemented to ensure patients received monitoring or a review when required.	

The practice did not have a system to identify the training requirements for each staff role.

The practice had ensured risk assessments had taken place however, where risks had been identified, there were no systems in place to ensure these had been reviewed or actions carried out.

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.	Partial
Explanation of any answers and additional evidence: At the last inspection in April 2022, we found there had been little leadership to provide and deliver vision, values and strategy during the COVID-19 pandemic. The provider told us they had concentrated on the day to day demands of the service and acknowledged there were some gaps in their provision. At the focused inspection in September 2022, we found the focus was on patient-centred care for all patients and there was a clear commitment and vision to reform the partnership to increase leadership at the practice. At this inspection in December 2022, we found the practice was still working towards reforming a partnership to sustain and grow the leadership and vision of the practice. The practice had focused on the day to day demands of the service and had ensured patients that required monitoring tests and reviews received them. However, as the practice had carried out limited audits, it was unable to evidence and monitor progress against its strategy.	

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**
<p>Explanation of any answers and additional evidence:</p> <p>*At this inspection in December 2022, we found the practice did not have a Freedom to Speak Up Guardian. Since this inspection, the practice told us the local Integrated Care Board have provided an external Freedom to Speak Up Guardian and their contact details had been shared details with the staff team.</p> <p>**At this inspection in December 2022, we reviewed the training matrix and identified 6 members of staff which included 3 GPs had not completed equality and diversity training. Following this inspection, the practice has informed us these members of staff have now completed this training.</p>	

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

Source	Feedback
Staff interviews	Staff told us they felt well supported and management were visible, accessible and approachable. Staff felt they had worked hard together as a team to improve the practice in response to the previous CQC inspections.

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

Governance arrangements

Responsibilities, roles and systems of accountability to support good governance and management were not always effective

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Explanation of any answers and additional evidence: At the last inspection in April 2022, we found the overall governance arrangements were ineffective, particularly with regard to monitoring the provision of clinical care. There was no appropriate oversight for the monitoring of repeat prescribing, clinical correspondence, acting on test results or routine reviews for patients with long term conditions. At the focused inspection in September 2022, we found improvements had been made but systems and processes had not been fully embedded into all areas of clinical care. At this inspection in December 2022, we found the systems and processes had been embedded into the areas of clinical care that we reviewed. For example, the practice had increased their capacity for blood test appointments which had supported their process to ensure patients were receiving reviews of their medical condition or their medicines at appropriate intervals. However, we found some areas of governance that were not effective or operating as intended as they had not identified the areas for improvement we found during this inspection. Staff told us they had appraisals within the last 12 months. However, appraisals for nurses were carried out by a non-clinical member of staff and areas for required development were not identified. For example, the appraisal for a nurse carrying out spirometry had not identified the specific training needed to carry this out and there was no assurance the nurse had completed this training. A targeted programme of regular audits was not taking place so the practice could not be assured they were reviewing their systems to ensure patient care and treatment was effective.	

Managing risks, issues and performance

Processes for managing risks and issues were not always effective and there was no effective process to review performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Yes

There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in April 2022, we found the practice did not have clear and effective processes for managing risks, issues and performance. Risks were not identified by the practice and therefore, not acted upon. Staff performance was not always monitored and not all staff had received an appraisal.</p> <p>At the focused inspection in September 2022, we found the practice had processes for managing risks, issues and performance however, they were not yet embedded in all areas.</p> <p>At this inspection in December 2022, we found the practice had implemented assurance systems to ensure patients received appropriate monitoring and review. For example, the practice was running searches on their clinical patient record system to identify patients that required a review, monitoring or a care plan and were inviting those patients in to ensure these took place. However, we found risks and issues were not always identified or dealt with quickly enough.</p> <p>The practice had carried out some audits for quality improvement purposes but there was no quality improvement programme in place.</p> <p>The process for storing blank prescription stationary had not been thoroughly risk assessed as there was still a <u>risk</u>, they could be removed without anyone being alerted.</p> <p>External agencies had carried out risk assessments and identified issues that required action. However, actions were not always noted or completed in a timely manner. For example, the need for a 5-year electrical safety check was identified twice this year through these external risk assessments but had still not yet been carried out meaning this identified risk was not managed appropriately.</p> <p>There was no oversight of the Do Not Attempt Cardio Pulmonary Resuscitation decisions to assure the practice the forms had been completed correctly, decisions had been made and recorded appropriately and they were being reviewed when necessary.</p> <p>There was no process to ensure staff, where required, had received appropriate vaccinations. There was no system in place to ensure non-clinical staff had the appropriate authority to administer vaccines by completing Patient Specific Directions.</p> <p>There was a process in place to respond to patient safety alerts however, this was not always effective which may leave patients at unnecessary risk.</p>	

Appropriate and accurate information

There was a commitment to using data and information proactively to drive and support decision making however, there was limited data available to staff to monitor and improve performance.

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
Explanation of any answers and additional evidence: At the last inspection in April 2022, we found the practice did not always act on appropriate and accurate information due to the poor management of correspondence, test results and safety alerts. At the focused inspection in September 2022, we found the practice had implemented systems to manage correspondence, test results and safety alerts however, these systems were not always effective. At this inspection in December 2022, we found the practice had effective systems to manage correspondence and test results however, we found the system for acting on safety alerts was not always effective as patients were not always informed of the alert.	

Governance and oversight of remote services

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

	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

Staff are supported to work remotely where applicable.	Yes
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Engagement with patients, the public, staff and external partners

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	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
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection in April 2022, we found the practice had suspended Patient Participation Group (PPG) meetings due to the COVID-19 pandemic.</p> <p>At the focused inspection in September 2022, we found PPG meetings were still not taking place.</p> <p>At this inspection in December 2022, we found PPG meetings had re-started.</p> <p>At this inspection in December 2022, we reviewed the minutes of 2 PPG meetings that had been held since the last inspection in April 2022. The PPG was made up of 4 patients who met with the lead GP and the practice manager. Issues relating to the practice were discussed and the PPG members are given an opportunity to ask questions. The minutes of the most recent PPG meeting stated the practice shared a summary of patient feedback gathered since July 2022 through the 'friends and family' scheme. The results showed 99 patients gave good or very good feedback and 12 gave poor or very poor feedback.</p>	

Feedback from Patient Participation Group.

Feedback
<p>We spoke to a member of the Patient Participation Group who told us they felt they could raise concerns or queries with the practice who were very good at listening and acting on suggestions. For example, the PPG member told us they highlighted the need for furniture to be fixed in the waiting area and this was acted on. The PPG member also told us people seemed very happy with their care and access at the practice.</p>

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence: At the inspection in April 2022, we found there was limited clinical quality improvement activity. At the focused inspection in September 2022, we found the practice there was no formal programme of targeted audits to provide quality assurance or improvements to patient care. The practice had, however, responded to the highest areas of risk that had been identified at the previous inspection. At this inspection in December 2022, we found although some audits had taken place, there was still a limited amount of activity regarding quality improvement. However, the practice had continued to respond to the highest areas of risk that had been identified in the previous inspections.	

Examples of continuous learning and improvement

The practice had supported and development staff and systems to improve the services they offer. For example, a member of staff has trained to become a care coordinator and to carry out phlebotomy (blood sample) appointments.

The practice was actively seeking the feedback of patients and had recently re-started Patient Participation Group meetings.

The practice told us they had recently reviewed their appointment booking system and had implemented changes they hoped would lead to a slight increase in availability.

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)	≤ -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.

