Care Quality Commission

Inspection Evidence Table

Dr Abdul-Kader Vania (1-493977210)

Inspection date: 14 April-22 April

Date of data download: 14 April 2021

Overall rating: Inadequate

The practice was previously inspected in January 2020 when the practice received an overall rating of **requires improvement**.

The effective domain and the population groups of families, children and young people, and working age people were rated as inadequate, whilst the safe and well-led domains were rated as requires improvement. The practice was rated as good for providing caring and responsive services, as were the population groups for older people; people with a long-term conditions; people whose circumstances make them vulnerable, and people experiencing poor mental health (including those with dementia). The provider was issued with a breach notice for Regulation 17 HSCA (RA) Regulations 2014 Good Governance. This was because:

- The practice had not established effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The breach notice stated that the provider must send CQC a report that says what action it is going to take to meet these requirements, but this was not received.

In addition, areas were identified where the provider **SHOULD** make improvements;

- Review cancer screening and childhood immunisation uptake systems to ensure that improvements in uptake are made.
- Ensure that oversight of training for staff is fully established and staff remain up to date.
- Review arrangements for appraisals and support mechanisms for staff to ensure that learning and development needs are addressed, and staff are held to account.
- Continue to identify and support those who are in a caring role.

Our inspection in April 2021 was undertaken to ensure that improvements had been made. We found that the practice had not made sufficient improvements, and it is therefore now rated as **inadequate** overall. We found that:

- The practice had not ensured that care and treatment was provided in a safe way.
- The practice did not ensure patients were protected from abuse and improper treatment.
- The practice had not established effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- The practice had not ensured that persons employed in the provision of the regulated activities received the appropriate support, training, supervision and appraisal necessary to enable them to carry out the duties.

Please note: Any Quality and Outcomes Framework (QOF) data relates to 2019/20.

Safe Rating: Inadequate

At our previous inspection in January 2020, we rated the provider as requires improvement for providing safe services because:

- The practice was not always able to demonstrate that systems in place to consider or mitigate risks were effective, or that there was an overall system of oversight to ensure systems were updated or working as intended.
- The practice was unable to demonstrate that systems to keep patients safe were effective or working as intended. The practice was aware of the majority of these and assured us that action would be taken to address these as soon as practicable.

At this inspection in April 2021, we found that the issues identified at the previous inspection had not been addressed. In addition, we found other areas of concerns impacting upon patient safety. The practice is therefore now rated as inadequate for providing safe services. This was because:

- Safeguarding processes were not adequate to protect patients.
- Appropriate recruitment checks had not been undertaken before employing new staff or locums.
- Staff immunisation status was not fully monitored.
- Findings from risk assessments were not acted on.
- The oversight of infection control and prevention lacked effective leadership.
- Information and guidance provided to staff was not sufficient to enable them to provide safe care.
- Medicines management required greater oversight to provide assurances that this was safely overseen.
- There was a need to produce better evidence of compliance in responding to incidents and safety alerts.
- A failsafe system was required for the management of cervical screening samples.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	N
There were policies covering adult and child safeguarding which were accessible to all staff.	partial
Policies and procedures were monitored, reviewed and updated.	N
GPs and practice staff were trained to appropriate levels for their role.	N
There was active and appropriate engagement in local safeguarding processes.	partial
The Out of Hours service was informed of relevant safeguarding information.	Y

Safeguarding	Y/N/Partial
There were systems to identify vulnerable patients on record.	N
Disclosure and Barring Service (DBS) checks were undertaken where required.	N
Staff who acted as chaperones were trained for their role.	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.	N

Explanation of any answers and additional evidence:

- The practice provided us with policies for child and adult safeguarding, both of which were dated 2019. The practice told us they were looking to update these towards the end of this year. However, we could not be assured that details in these policies were still correct, and the practice had not taken account of the requirement to review these policies when learning is shared, for example, from case reviews or updated guidance. The children's safeguarding policy still made reference to the Primary Care Trust (these were abolished in 2013). The adult safeguarding policy did not identify the designated practice lead, nor reflect the internal arrangements for recording a safeguarding adult concern. When interviewed, staff were not always clear on the reporting process.
- No alerts were recorded on patient records to flag any safeguarding concerns. This meant that clinicians would not be aware of the safeguarding issues when they accessed the home screen of the patient's records.
- There was no safeguarding register. The lead GP told us that he thought that the practice manager kept a spreadsheet but when we asked for assurance on this, nothing was provided. The lead GP was the designated safeguarding lead for the practice but we were not assured that they had an effective oversight of safeguarding in the practice.
- Our remote access to clinical records included a review of five records based on searches for patients coded as having safeguarding related concerns. Two of these were historical cases with safeguarding codes entered in the notes based on past history. One of the cases had the safeguarding code added to their record when they were registered with another practice, and it was unclear if the safeguarding issue was still active or resolved. A child was coded with a safeguarding concern in April 2018, but with no further review evident.
- The practice did not have any safeguarding or multi-disciplinary meetings in place at the time of our inspection to enable ongoing discussions on vulnerable children and adults. This had been highlighted at our previous inspection in January 2020. The practice told us that whilst they had planned to do this, it had been delayed due to the COVID-19 pandemic. However, no virtual meetings had been considered in this time although the practice told us they would discuss any individual concerns with the relevant professional as required. This did not provide evidence of a coordinated and holistic approach to safeguarding concerns.
- Staff induction documentation did not reference safeguarding awareness.
- We were provided with staff child safeguarding training evidence which was incomplete. At the site visit, we saw the majority of employed staff had completed safeguarding training and in most cases, this had been done after the inspection was announced. The practice child safeguarding policy stated the practice would ensure that all staff were trained to a level appropriate to their role, however one member of the team had only completed level one child safeguarding training, and another individual had no evidence of having completed it. It also stated that new starters would receive safeguarding training within six months of their start date, although they were not always achieving this timescale.

Safeguarding	Y/N/Partial
• The lead GP for safeguarding only had evidence of level one online training on their personal file, and nothing to indicate they had completed level three training. One GP locum file had no evidence of having completed any safeguarding training. • GPs were aware of local issues for their demographics and were able to provide some examples of safeguarding issues that had arisen and the actions that were taken. Evidence of safeguarding referrals being made appropriately was seen during the remote clinical records review.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	N
There were systems to ensure the registration of clinical staff (including nurses) was checked and regularly monitored.	N
Explanation of any answers and additional evidence: • Our interview with the practice manager indicated that annual checks were not done to ensure professional registration was maintained. We were told that these had been checked when locums had started working at the practice. However, the three GP locums had worked at the practice for nine, five, and over one year respectively. • Staff vaccination records were incomplete, particularly in respect of the GPs. • Recruitment checks were incomplete. Locums were directly contracted with the practice rather than through an agency, but the practice had failed to undertake many of the required recruitment checks for these five regularly used staff. It was unclear how checks were done for those locums used on an ad-hoc basis. • We found records of DBS checks were absent or historic in some records. This was highlighted as an issue at the last inspection in 2020. We saw that evidence of DBS clearance was transferred from previous employers which is not appropriate. This further added to our concerns with regards to assurance being evidenced from a safeguarding perspective. The practice told us that applications for DBS clearance were in progress for newly appointed staff and transferred DBS documents were being used in the interim. However, GP locum DBS checks had not been reviewed for some years, and there were none for the locum nurses. • We did see that recruitment information being collated since the appointment of the practice manager in July 2020 was much improved.	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 15.01.21	Y
There was a record of equipment calibration. Date of last calibration: 19.02.21	Y
There were risk assessments for any storage of hazardous substances for example, storage of chemicals, oxygen cylinder	partial

There was a fire procedure.	Y
A fire risk assessment had been completed. Date of completion: 31.5.2019	Y
Actions from fire risk assessment were identified and completed.	N

Explanation of any answers and additional evidence:

- A fire risk assessment had been completed in May 2019 by an external contractor. This identified three actions for the practice to undertake by the summer of 2019 relating to the installation of emergency lighting on the upper floor; the servicing of emergency lighting already in situ; and the periodic inspection of the site's electrical installation. The action plan had not been updated and we were not provided with evidence that the work had been completed, or that an interim risk assessment had been considered. This issue was highlighted at the previous inspection. We were informed a new fire risk assessment had been organised to take place on 11 May 2021.
- We were told the practice had undertaken a risk assessment in relation to the storage of their oxygen cylinder. However, the evidence provided was a generic protocol which did not reflect the storage of oxygen cylinders in the practice.
- The last health and safety audit undertaken in 2019 stated 'ensure the area where the oxygen bottle is kept is appropriately signed', however, we found the oxygen was stored in a cupboard within reception marked 'oxygen' without appropriate signage. Compressed gas cylinders are required by law to carry and display hazard warning signs and Control of Substances Hazardous to Health (CoSHH) warning symbols to minimise the risk of injury. It was not included in the practice's CoSHH risk assessments as a hazardous substance.

Health and safety	**Y/N/Partial**
Premises/security risk assessment had been carried out. Date of last assessment: 31 May 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 31 May 2019	N

Explanation of any answers and additional evidence:

- The practice provided us with a copy of a health and safety audit action plan which had been undertaken by an external contractor. This highlighted a number of actions for completion by the end of July 2019, including undertaking an asbestos survey for the site, and to ensure that an inventory for any hazardous substances was updated with clear reference to storage, disposal, associated personal protective equipment and first aid measures in the event of a spillage. We saw limited evidence that the action plan had been acted upon and the action plan had not been updated since issued. The practice told us they had arranged for a further health and safety audit which was booked for 11 May 2021.
- Work had commenced to improve the risk assessments for CoSHH, but at the time of our inspection, only four had been completed.
- We saw no evidence that the practice undertook their own site checks for health and safety compliance.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
There was an infection risk assessment and policy.	partial
Staff had received effective training on infection prevention and control.	N
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 28.10.20	partial
The practice had acted on any issues identified in infection prevention and control audits.	partial
There was a system to notify Public Health England of suspected notifiable diseases.	N
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

- The practice provided us with their infection control policy. This was dated May 2013, with an update recorded in February 2021. The policy was extremely limited and made no reference to key aspects of infection control. The policy did not include the contact details for the local infection and prevention control team or Public Health England. The policy highlighted several areas of responsibility but in many cases these were blank rather than the responsibility being assigned to anyone – for example, "The staff member responsible for training and the annual audit of infection control is [*Insert name*]".
- Some other policies related to infection control were provided on request. These were generic and not customised to the practice. They provided no assurance in terms of the process within the practice. There was no indication where polices may link together – for example, we were provided with a policy on sharps management, this made no mention of what to do in the event of a sharps injury.
- The GP was the designated infection control lead as there was no employed practice nurse in post. Due to the internal and external commitments of this GP, the leadership provided in infection control was not evident.
- We did not see evidence that locum staff had undertaken infection control training, or that the lead GP had done any infection control training in support of their lead role.
- We asked a member of the team about personal protective equipment (PPE) with regards to protection against COVID. This highlighted some gaps in knowledge. We were told staff had received no training on PPE geared to COVID.
- When we queried the use of PPE, we were informed staff had asked another practice about the use of aprons in COVID vaccination clinics**.** However, we would expect the infection control lead to have consulted the national guidance and communicated the practice's approach to their team as an evidence-based response to this issue, and to consider a formal protocol/policy update.
- The practice provided a COVID-19 policy. This was not comprehensive in terms of providing a framework for staff to work within. It contained no reference to patient interactions.
- The practice provided an infection control audit dated October 2020 which had been undertaken by a Clinical Commissioning Group (CCG) infection prevention and control lead as part of CCG assurance visits during the COVID-19 pandemic. This audit highlighted many areas of non-compliance. The CCG infection prevention and control lead had re-visited the practice in early

December 2020 to review progress with the action plan, and indicated that good progress was being made, although a number of actions were still in progress. However, there was no clear documented evidence to demonstrate this. The practice had re-done the audit using the same audit tool in January 2021, however, this was unclear as to the outcomes achieved, and there was no associated action plan.

- We requested a copy of the policy for cleaning medical equipment but this was not provided. We were informed there was not a policy or protocol for cleaning up spillages.
- At our site visit, we found the premises to be clean and tidy. We saw that weekly and monthly cleaning schedules were in place, and these were ticked off. However, they did not include initials or a signature to indicate who had completed them.

Risks to patients

There were gaps in systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	N
There was an effective induction system for temporary staff tailored to their role.	N
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	partial
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.	N

Explanation of any answers and additional evidence:

- A locum nurse informed us they had been off work for two weeks just prior to our inspection, but no additional nursing cover was provided at the practice in their absence. This further limited options for patients who were only able to access nursing on site one day a week. This impacted upon the lower achievement in child immunisations, cervical screening and reviews for the Quality and Outcomes Framework.
- There was no induction pack available for locum staff. Practices need to ensure that all of their staff (including locums) have the appropriate training, induction and access to accurate information that will allow them to safely and effectively manage patients. Locum nurses and GPs need access to essential information to ensure they are able to work safely in a practice.
- A member of the administration/reception team informed us they had guidelines in the form of a flow chart for any patients presenting with chest pain or anaphylaxis. Evidence was provided to support this. When we asked about other guidance on presenting emergencies including sepsis, this was an area where staff required further training and guidance.
- Whilst the reception team signposted patients to services, we were told there was no written guidance and any new staff would just be informed verbally what to do.
- Following the inspection of the circumcision clinic we asked the GP to provide:
  - A risk assessment of moving baby from the waiting room downstairs to the first-floor treatment room.
  - A risk assessment of using the restraint device, a cushion, which we were informed was a specialist device designed especially for infant circumcision.

  We received a response from the provider but a formal documented health and safety risk assessment was required to demonstrate moving and handling in a safe way.

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.	partial
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	partial
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	partial
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	partial

Explanation of any answers and additional evidence:

- There was no failsafe system in place for cervical cytology samples. Failsafe is a back-up mechanism to ensure that all samples sent to the laboratory are recording when sent, and when the results have been returned. This ensures any samples sent for analysis that are not reported on, can be identified and followed up appropriately. We were informed that individual results were filed in the patient's record, but not monitored as part of a failsafe process.
- Evidence was seen that two-week wait referrals were being made promptly using a template. However, no safety net advice was recorded in the patient notes for them to contact the provider if they had not been reviewed in two weeks. A member of the team told us that patients were told this, however, it was not documented.
- We were not assured that the processing of information on new patients worked effectively. For example, we saw that safeguarding had been coded but no alert was placed on the records and there was no evidence of the safeguarding concern being reviewed. We also saw that a new patient had registered over 12 months ago with test results from the previous practice indicating a potential diabetes diagnosis. Whilst the patient had been advised to book further blood tests, there was no evidence this had been followed up.
- The practice used a type of software to make communications between patients and healthcare professionals easier, and this was being used extensively to send text messages to patients. Whilst this is efficient and can give focused information (e.g. cholesterol advice), we observed it was being used for more complex patient care management on occasions.
- We saw that a patient had been asked to undertake their own blood pressure reading at home and submit the results to the practice. The GP then issued a prescription without any discussions with the patient to consider any safety netting advice or general advice.
- Systems to share information between clinicians to ensure risks to patients were considered or addressed were not always effective.
- We were provided with examples of emails sent to other professionals relating to patient care, but we did not find information was being shared as part of a holistic approach.

- We saw that GPs of children who received a circumcision were contacted by letter to inform them that the procedure had been undertaken.

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2020 to 31/12/2020) (NHS Business Service Authority - NHSBSA)	0.25	0.65	0.76	Significant Variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2020 to 31/12/2020) (NHSBSA)	7.9%	9.5%	9.5%	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 (01/07/2020 to 31/12/2020) (NHSBSA)	3.68	4.72	5.33	Tending towards variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	21.4‰	89.0‰	127.0‰	Significant Variation (positive)
	-	-		-

- Antibiotic prescribing at the practice was lower than local and national averages. The practice explained that they had achieved this by ensuring that they did not prescribe antibiotics until absolutely necessary. They also explained that they educated patients in good antimicrobial stewardship and worked with patients to keep the numbers of requests for these medicines down.

- The practice approach was not to prescribe benzodiazepines and opioids, which resulted in low prescribing rates for these medicines for a number of years. New patients were advised about this policy via a 'Help Us To Help You' guide and given a short course of repeat medication to reduce dependency. The practice had also obtained agreement with the local mental health team that they would not prescribe benzodiazepines on their behalf.

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.	N
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	PGDs - partial PSDs – N/A
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.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	partial
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 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.	partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	partial
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

Explanation of any answers and additional evidence:

- There was no system for tracking prescription stationery. We found a large stock of blank prescriptions in a locked cupboard but this could be accessed by all staff members. There was no system to log prescriptions on receipt or upon their distribution throughout the practice. We were told there was no practice policy for the management of blank prescriptions. This meant that prescription paper was insecure and could potentially be used to obtain unprescribed medicines. This was not in line with the NHS Counter Fraud Authority guidance on the management and security of prescription stationery. The practice told us they were mainly using

Medicines management	Y/N/Partial

electronic prescribing in response, demonstrating a lack of awareness and ownership of this issue.

- We found that Patient Group Directives (PGDs) were in place which were signed by the two regular locum nurses and the GP. However, we found two other PGDs which had been pre-signed by the GP in 2020 but without any nursing signatures. We were unsure why these had been signed in advance, rather than being approved after the nurse had signed. We asked the practice to provide feedback on this issue but nothing was received. (A Patient Group Directive is a written instruction on the administration of medicines to a group of patients who may not be individually identified before presentation for treatment.)

- The GP remote searches flagged up an issue with the monitoring of medicines. This related to creatinine clearance being calculated which is guidance when prescribing NOACs (a class of anti-coagulant medicine). By not doing this, there is a risk that the dose prescribed may be too high or too low, and this creates a potential risk of haemorrhage or thrombosis. The searches also identified some patients missing monitoring checks. The areas identified by the searches were predominantly low risk and we saw there was some mitigation in the actions recorded in the patient records. Nonetheless, there was some scope to reinforce some processes to 'close the loop' including making sure that when issues were identified they were followed up. For example, if the patient was asked to book a blood test and subsequently did not attend, there should be a tighter system in place to monitor this.

- At our previous inspection in July 2020 the practice did not stock all the recommended emergency medicines, or had considered the risk of not having these and documenting this in a risk assessment. The practice made the decision to stock all recommended emergency medicines and we saw that this was largely resolved. However, there was no hydrocortisone for injection available and no risk assessment had been considered.

- The practice had a system to check the availability and expiry dates for emergency medicines and provided us with a weekly checklist starting from the end of January 2021, and we were told this system was introduced in January as the checks were not embedded prior to this. The weekly checklist had gaps, for example checks were recorded on 12 February, then 24 February, followed by 10 March, and then 1 April. We were told that managers were aware of this issue and were putting systems in place to ensure staff duties were covered when an individual was not at work.

- We raised a concern with regards the use of a topical numbing cream for children under the age of 12 months in the circumcision service. We were informed by the GP that this cream was suitable for infants from the age of one month. However, the cream is licensed for children from the age of one year.

Track record on safety and lessons learned and improvements made

The practice did not have an effective system to learn and make improvements when things went wrong.

Significant events	Y/N/Partial

The practice monitored and reviewed safety using information from a variety of sources.	N
Staff knew how to identify and report concerns, safety incidents and near misses.	partial
There was a system for recording and acting on significant events.	partial
Staff understood how to raise concerns and report incidents both internally and externally.	N
There was evidence of learning and dissemination of information.	N
Number of events recorded in last 12 months:	6
Number of events that required action:	6

Explanation of any answers and additional evidence:

- We were not assured that all events were being captured as part of the significant event process. For example we saw an email dated 3 March asking for an appropriate issue to be considered as a significant event, but this was not included in the summary provided to us by the practice.
- Discussions with staff highlighted other incidents which did not appear on the incident report summary provided.
- There was limited evidence to demonstrate that learning from incidents was being shared effectively. A regular locum clinician told us they did not receive any feedback on learning from significant events. We saw brief reference to one incident in minutes from a staff meeting in January 2021.
- We saw a significant event had occurred when a locum labelled a cervical cytology sample with the wrong person's information. We queried duty of candour as the incident made no reference to this, however, we saw that the patient was contacted by telephone, received an apology and was told they would to have the procedure repeated. Duty of candour is a regulation and one of the fundamental standards of CQC registration, and we would expect staff to be conversant with this term.
- We were told that the practice recorded all significant events on Clarity TeamNet, an intranet web-based sharing and compliance platform used by GP practices. However, we were not assured that this was an effective mechanism to communicate with five regular locum staff who mostly worked very limited hours (GP locums were usually on site for two hours). This provided very little opportunity to do more than the one and a half hours of patient consultations, and half an hour for administrative time.

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

Event	Specific action taken
A new registration form for a patient to see the midwife was completed. The action was for staff to put this into the tray for the midwife to pick up when next attending the surgery. Six weeks later, the patient contacted the surgery concerned she had not been contacted by midwife yet. This highlighted that the form had been lost.	A new process was introduced whereby the new referral form was scanned to the patient's records before being placed in the midwife's tray. This was also recorded on the clinical system, and a task would be sent to the midwife to highlight there was a new referral.

A cervical cytology patient specimen was labelled with another patient details. This was highlighted by the laboratory as the form attached with the sample was for a different patient. The results were therefore not usable and the patient was contacted and informed.	The learning recorded was stated as “ensure label printer compatible for when locum account so they can print as they go along”. This was unclear. There was no reference to duty of candour or the review of systems undertaken. There was a lack of focus on identifying the root causes and learning in response to the incident.

Any additional evidence or comments

- There was an incident recorded in which heating timers were incorrectly set meaning the heating was left on full all weekend. The learning points stated “cost of this, fire risk, and timers set”
  This raised concerns as the practice were highlighting a potential fire risk but the incident had no corresponding record of any risk assessment being developed in response to minimise the risk of occurrence. This added to the concerns raised by the action plan from the fire risk assessment in 2019 not being completed.

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

Explanation of any answers and additional evidence:

- The practice received safety alerts including those from the Medicines and Healthcare products Regulatory Agency (MHRA). The practice told us these were maintained on a log and also on the practice intranet system for reference. We were advised that clinicians were sent the alert including the PCN employed pharmacist, who undertook any patient searches required, and would then liaise with the practice manager or GP as appropriate. The log did not give clarity about how the alert was actioned and was only implemented in October 2020, making it difficult to understand the outcomes for any alerts received more than six months ago. The week following the site visit, we were provided with a MHRA log maintained by one of the PCN pharmacists from February to April 2020. This was a very comprehensive document that provided assurance for this three month period that MHRA alerts had been effectively reviewed. This had stopped in April 2020 due to the pharmacist going on leave. We were informed that there was a plan for the pharmacist to work with the practice manager to implement an effective system for alerts when they returned to work. However, the practice still needed to consider the gaps pre-April 2020 and from April to November 2020.
- Our remote searches of the system did not provide assurance that historical alerts had been acted upon or kept under review. For example, patients prescribed a particular medicine to reduce blood sugar should receive advice on the potential risk of a very rare but potentially serious side-effect . We reviewed one patient’s record who had been prescribed this medicine but there was no documented evidence to show the risk had been discussed with them.

Effective Rating: Inadequate

At our previous inspection in January 2020, we rated the provider as **inadequate** for providing effective services because:

- The practice cervical screening and childhood immunisations uptake rates were lower than local and national averages. Although aware of this, the practice was unable to demonstrate any actions taken to address this.
- The provider was unable to evidence that systems were in place or working effectively in relation to sharing information with other organisations or professionals. For example, Multi-Disciplinary Team (MDT) meetings or those involving health visitors.
- In addition, the practice was also unable to demonstrate that the system in place to ensure quality improvement was fully effective or being used to make improvements.

At our inspection in April 2021, the practice remains rated as **inadequate** for providing effective services. This is because:

- Cervical screening rates had declined since our previous inspection. We saw no evidence that the practice had acted on addressing this since our previous inspection.
- Childhood immunisation rates all remained below the minimum target. Some indicators had improved, whilst others had deteriorated. A locum nurse told us how she had implemented some systems recently to try and improve uptake. However, we saw limited actions from practice leaders to address the issue.
- Performance in the Quality and Outcomes Framework (QOF) for 2019-20 showed lower outcomes for patients compared to local and national averages. There was limited practice nurse input and therefore a lack of clinical co-ordination to effectively manage long-term condition reviews.
- The practice had not taken action to address the absence of multi-disciplinary meetings highlighted at our last inspection. No consideration had been given to set up virtual meetings during the COVID pandemic.
- We were provided with one incomplete clinical audit. There was limited evidence of a wider quality improvement programme in the practice.
- The practice continued to be reliant on locum clinical input. We were not assured that locums had received an appropriate induction or training, and assurances on the quality of their input could not be demonstrated.
- Clinical meetings did not take place and although there were mechanisms for communication, they lacked a coordinated and structured patient centred approach.

Effective needs assessment, care and treatment

Patients' needs were not fully assessed, and 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.	partial

Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	partial
We saw no evidence of discrimination when staff made care and treatment decisions.	N
Patients' treatment was regularly reviewed and updated.	N
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.	partial

Explanation of any answers and additional evidence:

- The lead GP told us he relied on GPs to keep themselves up-to-date with latest guidance. The practice also used tasks on the clinical system, and a mobile application (app) group for GPs, to share information on new guidance and journal articles - for example, recent guidance on headache after the Astra-Zeneca COVID vaccination.
- No clinical meetings were held on site. The provider told us this was not possible as the locums worked on different days. However, the practice had not considered other ways of engaging clinicians in appropriate discussions other than via an app. This meant evidence of a coordinated clinical approach within the practice was not always apparent.
- A Primary Care Network (PCN) employed pharmacist would update GPs regarding new local guidelines, for example, a recent change to the cellulitis pathway.
- We observed that some care plans had not been updated since 2019. There was some mitigation with this due to the COVID pandemic.
- Our remote access to records indicated that patients presenting with symptoms which could indicate serious illness were not always followed up in a timely and appropriate way. For example, where further follow up had been indicated (for example, more blood tests), this was not always completed.
- We saw that when medicines had been prescribed, they often had no evidence of any associated risks being discussed in the notes and some stated to refer to the information leaflet with the medicines and to seek advice/help promptly if unwell.

Older people

Population group rating: Requires improvement

Findings

- The practice had a relatively small older population of approximately 160 patients.
- Patients highlighted with complex health needs could be referred to care navigators to access appropriate support services. However, in the absence of multi-disciplinary meetings, we were not assured that holistic care was planned and provided.
- The Primary Care Network employed a social prescriber to whom the practice could refer patients.
- The practice had a system to help patients to order medication by ordering repeat prescriptions on the patient's behalf with family consent. However, it was unclear how the practice monitored compliance in taking medicines before ordering more supplies, or reviewed that items were still required.
- Home visits were available. Patients were referred to a home visit service commissioned via the local Clinical Commissioning Group (CCG), although we were informed that GPs would undertake their own visits if required.
- The practice told us that they used a clinical tool to identify older patients who were living with moderate or severe frailty, and these patients received an assessment of their physical, mental and social needs.

- The practice told us they followed up on older patients discharged from hospital. The PCN pharmacist reviewed any changes to medicines and advised GPs.
- Health checks were offered with the health care assistant to patients over 75 years of age. Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions — Population group rating: Inadequate

Findings

- In the absence of an employed practice nurse, GPs were responsible for the majority of long-term condition management. One of the locum practice nurses who worked one morning per week at the practice told us they did some asthma and diabetic reviews.
- In the most recently published outcomes in the Quality and Outcomes Framework (QOF) 2019-20, we saw the practice achieved 77.9% for clinical outcomes (CCG 92.5%, national 94.6%). We saw that outcomes were particularly low for diabetes (59.4%), atrial fibrillation (59%), and mental health (70%), and that these were significantly lower than local and national averages. We were told that a structured plan had been put in place to address this, however, the practice had no documented evidence or minutes to reflect this.
- Our remote access to the clinical system demonstrated that some patient management plans had not been reviewed since 2019.
- Patients with long-term conditions were not always offered a structured annual review to check their health and medicines needs were being met. For example, we found no evidence of annual monitoring or patient reviews for those being prescribed ACE inhibitors.
- We were told the recently appointed health care assistant was undertaking training in a programme to help patients that had been identified with pre-diabetes. However, we were unclear how the HCA was being overseen or mentored in their role. There was no documentation to support this, although we were told they would be able to seek advice from a GP if required.
- We saw limited evidence of multi-disciplinary working to support patient care. Therefore, clear and accurate information was not routinely shared with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice did not demonstrate how they identified patients with commonly undiagnosed conditions, for example, our remote system searches identified two patients with a missed diagnosis of diabetes. The prevalence of all long-term conditions was well below the CCG average figures.
- The practice accessed support from community services such as heart failure and respiratory specialist nurses.
- Shared care monitoring was in place for patients on stable specific medication initiated by secondary care.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	83.0%	76.9%	76.6%	No statistical variation

PCA* rate (number of PCAs).	2.8% (3)	5.7%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	94.1%	89.7%	89.4%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	9.3%	12.7%	N/A

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	77.1%	82.5%	82.0%	No statistical variation
PCA rate (number of PCAs).	5.4% (2)	3.7%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	55.6%	67.7%	66.9%	No statistical variation
PCA rate (number of PCAs).	11.5% (14)	10.4%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	73.0%	73.2%	72.4%	No statistical variation
PCA rate (number of PCAs).	5.7% (9)	4.6%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	90.0%	93.6%	91.8%	No statistical variation
PCA rate (number of PCAs).	9.1% (1)	3.4%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	68.7%	73.5%	75.9%	No statistical variation
PCA rate (number of PCAs).	5.7% (7)	6.9%	10.4%	N/A

Families, children and young people Population group rating: Inadequate

Findings

- The practice had not met the minimum 90% for all five childhood immunisation uptake indicators. One locum nurse who worked one morning each week at the practice informed us about how they were focusing on non-attenders by sending letters and having telephone conversations to discuss the importance of vaccination. However, we saw a lack of evidence of a proactive approach to increase uptake over the last year despite this being one of the main concerns highlighted at our previous inspection. We were informed that plans were imminent to arrange pre-booked appointments for initial letters being sent to parents/carers in an attempt to increase uptake.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The approach to safeguarding did not provide assurance that patients with safeguarding concerns were regularly reviewed.
- Young people were referred to a sexual health service in the city to access services for sexual health and contraception.
- A private circumcision service was held on site twice a week. We identified some concerns with this including the use of a numbing cream outside of its licence.
- The practice was not able to demonstrate that staff had the appropriate skills and training to carry out reviews for this population group as we did not see evidence of immunisation training for one of the locum nurses.
- The midwife held a regular clinic at the surgery and was able to liaise with the practice team when she attended.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) (i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	30	47	63.8%	Below 80% uptake
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	42	48	87.5%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	40	48	83.3%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles,	42	48	87.5%	Below 90% minimum

mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)				
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	59	74	79.7%	Below 80% uptake

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

Any additional evidence or comments

The percentage of children aged 1 who had 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):

- At the previous inspection in January 2020, the practice achieved 87% uptake, but the latest verified data for a full year showed this had decreased to 63.8%.

The percentage of children aged 2 who had received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster):

- At the previous inspection in January 2020, the practice achieved 69.4% and showed as a significant variation. The most recent verified data showed an improved outcome at 87.5%. However, this was still below the 90% minimum target.

The percentage of children aged 2 who had received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC):

- At the previous inspection in January 2020, the practice achieved 69.4% and showed as a significant variation. The most recent verified data showed an improved outcome at 83.8%. However, this was still below the 90% minimum target.

The percentage of children aged 2 who have received immunisation for measles, mumps and rubella:

- At the previous inspection in January 2020, the practice achieved 67.3% and showed as a significant variation. The most recent verified data showed an improved outcome at 87.5%. However, this was still below the 90% minimum target.

The percentage of children aged 5 who have received immunisation for measles, mumps and rubella:

- This data was not included in the previous inspection evidence table. It was noted this indicator was a significant variation as it had achieved below 80% uptake.

It was acknowledged that the COVID pandemic would impact on performance in this area, although this was a long standing area where the practice had performed below local and national averages.

We discussed how the practice was trying to improve performance for childhood immunisations as this was identified as a significant concern at the previous inspection in January 2020. They told us that they were currently working with an external service to promote pre-booked appointments when contacting parents to encourage attendance. It was hoped this would be implemented in May 2021. However, we did not see evidence of work to drive improvement in this area following our last inspection.

We were aware that the practice only had two practice nurse sessions available on site on the same day of the week, limiting options in access for parents. At the time of our inspection, one of the nurses was providing COVID vaccinations, thereby further reducing capacity for immunisation appointments. We spoke with one locum practice nurse who was actively targeting non-attendance to try and improve the uptake rates. This included telephone calls to parents to stress the importance of immunisations and to

try and address any concerns they might have. This was noted as a good response to the issue, which should impact upon uptake in the future.

Working age people (including those recently retired and students) — Population group rating: Inadequate

Findings

- The practice had not met the 80% target uptake for cervical screening. Rates had dropped from 56.2% at our last inspection to below 50%. This was highlighted as a significant concern at our last inspection but the practice was unable to provide any verified data to demonstrate that improvements had taken place. The outcome was impacted upon by the lack of nursing hours provided on site. The practice was further unable to demonstrate any proactive actions taken to address the low uptake in the last year. Following our inspection, updated verified data showed a minimal improvement from 49.9% (September 2020) to 51.8% (December 2020), but this was still significantly below the 80% national target.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- Patients could not book or cancel appointments online at the time of our inspection in line with COVID guidance. However, patients could still order repeat medicines without the need to attend the surgery.
- GP appointments were available from 7.30am on three mornings of the week, and a locum nurse provided appointments once a week until the practice closed at 6.30pm. However, appointment times were less flexible at other times in the week as a GP only provided a consulting session for 1.5 hours/day and the nurses were only available on a Thursday.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 30/09/2020) (Public Health England)	49.9%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	59.0%	62.2%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2019 to 31/03/2020) (PHE)	50.6%	N/A	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)	20.0%	92.1%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two	25.0%	53.4%	54.2%	No statistical variation

week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)				

Any additional evidence or comments

- Whilst there may have been some impact on the cervical screening uptake due to COVID-19, this figure had been low for more than five years. Our data goes back to March 2016 when the practice achieved a 63% uptake, but it had achieved results below this figure ever since. The practice had not developed any clear actions to improve uptake since the last inspection in January 2020. Whilst the practice highlighted language barriers as an issue, they had not sourced information leaflets on screening in different languages
- The uptake rates for bowel and breast screening were below national averages and uptake rates had only increased minimally since the previous inspection.
- The number of new cancer cases detected as a result of a two-week referral was significantly below local and national averages, as were reviews of newly diagnosed cancer patients. Neither of these indicators had showed improvement since the previous year's data. However, it is acknowledged these figures may be skewed by low patient numbers.

People whose circumstances make them vulnerable

Population group rating: Requires improvement

Findings

- The practice provided primary care services to a care home for people with learning disabilities. The practice told us they liaised with the home manager to support patient care, and that longer appointments were offered in recognition of their needs.
- Patients with a learning disability were offered an annual health check. We saw the practice had undertaken an annual review for 50% of the patients on their learning disability register.
- The practice told us there was no end of life register at the time of inspection, and could only recall two palliative care patients in recent months.
- 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 refer people who misused substances and alcohol for support.
- We asked the practice how they had ensured communications with vulnerable patients throughout the pandemic but were told this was left with patients to contact the surgery if they needed assistance.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires improvement

Findings

- The practice had achieved 70% for mental health indicators during 2019-20 as part of QOF. This was 19% below the CCG average and 20% below the national average.
- The practice told us they assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.

- When patients were assessed to be at risk of suicide or self-harm the practice informed us they had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. The practice had very few patients with dementia.
- Patients with poor mental health were referred to appropriate services. The Primary Care Network employed a social prescriber and mental health facilitator, and the practice accessed them to support individual care for patients with mental health conditions. We were informed that patients were encouraged to use services such as talking therapies and cognitive behavior therapy.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	76.2%	84.3%	85.4%	No statistical variation
PCA rate (number of PCAs).	4.5% (1)	11.3%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	75.0%	83.8%	81.4%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	8.1%	8.0%	N/A

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	459.32	Not Available	533.9
Overall QOF score (as a percentage of maximum)	82.2%	Not Available	95.5%
Overall QOF PCA reporting (all domains)	7.4%	Not Available	5.9%

Any additional evidence or comments
• The outbreak of COVID-19 in the last quarter of 2019-20 led to unprecedented changes in the work and behaviour of GP practices and consequently the data may have been impacted upon. We acknowledge that Leicester was in lockdown due to the pandemic from June 2020, and QOF was paused in April 2020 and then resumed in November 2020. More recently the practice has been a site for administering COVID vaccinations since January 2021 which again impacted on capacity. However, the QOF data used in this report relates to 2019-20 and the practice's

performance in QOF was well below local and national figures, but we do acknowledge that the pandemic would have had some impact towards the end of the QOF year.

	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.	partial
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

- The GP provided one cycle of an audit, but this had not been formally documented to identify actions taken and plans for the second cycle which would be good practice. The audit looked at LDL (bad) cholesterol levels to identify those who may have familial hypercholesterolemia as is more common for the demographic of patients largely served by the practice. This identified 55 patients who were sent a standard letter offering a statin and a referral to the Lipid Clinic. Approximately 20 patients agreed to take a statin and be referred, but outcomes on these referrals was awaited. The GP told us there were plans to repeat a second cycle of audit in late summer 2021 to see how many of the patients who had been treated have seen a 50% reduction in LDL cholesterol levels and therefore, cardiovascular risk.
- There was no practice audit plan although we were informed the GP was in the process of auditing patients with hypertension to see if they were being treated to European Society of Cardiology (ESC) targets and offering seven-day blood pressure monitoring on an adhoc basis when reviewing medication.
- Pharmacists employed through the Primary Care Network undertook regular medicine audits and reviews and shared the finding with the practice. An example of learning being shared from this included the pharmacist identifying through a prescribing audit that the GP had prescribed the wrong dose of a medicine as per recent changes to the cellulitis pathway. GPs were advised regarding this guidance.

Any additional evidence or comments

Effective staffing

The practice was unable 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.	N
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.	partial
Staff had access to regular appraisals, one to ones, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	N
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N/A
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

- The practice was not employing any clinical staff on a permanent basis at the time of our inspection apart from a recently appointed health care assistant for 12 hours per week. The sole permanent professionally qualified clinical staff member was the GP provider. There were three long-term GP locums who worked between one and three sessions each per week, and two locum practice nurses who each worked one session a week.
- A health care assistant (HCA) has been employed at the practice since January 2021 for 12 hours/week over two days. The HCA did not work on the same day as the nurses so it was unclear as to how they received support and mentorship. We were informed that one of the locum practice nurses had assisted with training and attended the practice on additional days to support the process, but no evidence was provided to support this. Therefore, it was unclear how the practice could provide assurances on the oversight and supervision of their work.
- At the previous inspection we highlighted gaps in staff training and the effective oversight and co-ordination of staff training. At this inspection in April 2021, we were provided with a training evidence matrix. This did not include the health care assistant or GP, nor take account of long-term locum staff. Reviews of staff files demonstrated gaps in training. We saw no evidence that one locum nurse had completed the required training for cervical screening or childhood immunisations.
- The non-clinical practice team were new, the longest substantive employee having been in post for just eight months. We were told that the previous employees had all left the practice around the same time, and this clearly meant that organisational memory (i.e. the accumulated body of data, information, and knowledge created in the course of an individual organisation's existence) was impacted upon. The practice manager told us they were able to get support from other practice managers in the area, and staff told us they felt they were well supported. However, we did not find that staff had the awareness of previous concerns to be able to have addressed these effectively with clear direction and guidance from the provider.
- Appraisals had not taken place as staff had been in post less than a year, we saw no evidence of competency assessments or probation reviews for new staff.
- Our interviews of staff highlighted a number of issues where team members required more training and advice. This included local safeguarding processes, duty of candour, the CQC notification process, and specific issues relating to COVID and infection control.
- We found that the practice had established a good working relationship with the PCN's social prescriber, and we were informed of how this had produced some positive outcomes for patients. This was a good example of working with other community-based health and social care professionals, but we found limited evidence of how this approach was being developed with other professionals and teams.

Coordinating care and treatment

Staff did not work 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.	N
Patients received consistent, coordinated, person-centred care when they moved between services.	N
Explanation of any answers and additional evidence: • At the previous inspection in January 2020, the practice could not demonstrate that multi-disciplinary team (MDT) meetings had taken place. These meetings were still not in place at the time of this inspection in April 2021. We were told that health and social care colleagues were contacted on an individual basis as required to discuss patients. We saw no evidence that online meetings had been attempted to facilitate this after our previous inspection. • We were informed that communication with district nurses was via telephone or a task on the clinical system on a case by case basis. • The reception team helped to coordinate care, for example, we were told reception staff had contacted a patient's community psychiatric nurse and then contacted the patient to inform them of the plans for their care.	

Helping patients to live healthier lives

Staff did not always help 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.	N
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.	partial
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	N
Explanation of any answers and additional evidence: • The lack of a holistic approach did not provide assurances on a coordinated approach to care. • The practice had only identified 0.1% of their patients as carers. Due to their demographics, we were not assured that enough had been done to identify young carers. • Smoking cessation and weight management were discussed in consultations with patients, and patients could be signposted for services to help them. However, many of these services were not available at the time of the inspection due to the pandemic • The practice told us they were keen to promote NHS health checks to help identify patients with diabetes and hypertension. However, we were unsure how accessible the checks were as the health care assistant only worked 12 hours/week.	

Consent to care and treatment

The practice mostly 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.	partial
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.	partial

Explanation of any answers and additional evidence:

- Our inspection of the circumcision clinic highlighted that language barriers created some confusion. We observed a situation in which parents were not prepared for the fact that their child would be taken away to a separate area to have the procedure. Whilst this was explained as part of the booking-in process and confirmed in arrangements sent by email, it was clear that the parents had not understood this. The practice had not considered how it communicated with parents with regards how the circumcision clinic operates, for example, by providing information sheets in different languages.
- A remote search identified six DNACPR decisions on patient records and five of these were randomly reviewed. Four of these had the DNACPR initiated in secondary care but had the DNACPR documented and coded in their clinical record. The other patient had their DNACPR arranged by the practice. This did not include selecting an option as to whether this was indefinite or for review after a specified timescale, which is a requirement of the DNACPR to ensure this can be changed if required.

Well-led Rating: Inadequate

At our previous inspection in January 2020, we rated the provider as **requires improvement** for providing well-led services because:

- The practice was not always able to demonstrate that systems in place to consider or mitigate risks were effective, or that there was an overall system of oversight to ensure systems were updated or working as intended.
- The practice was unable to demonstrate that systems to keep patients fully safe or to oversee systems and process in relation to overall governance, were effective or working as intended, which led to gaps in risk management and overall governance systems.

The practice was issued with a Regulation 17 (good governance) breach notice following the previous inspection and told they must make improvements to establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

At our inspection in April 2021, we found limited evidence that the provider had responded to our concerns and therefore the practice is now rated as **inadequate** for providing well-led services:

- We saw no evidence of a co-ordinated plan being developed in response to our previous inspection. There was no action plan and no staff engagement to effect change and to deliver compliance with fundamental standards.
- We did not find evidence of clear and effective leadership. The provider was disengaged with the process of responding to the previous outcomes of the inspection.
- Governance arrangements were not working effectively.
- The practice was unable to demonstrate that there were effective systems in place to manage and mitigate risks.
- The provider was unable to provide assurances that staff were working competently with effective oversight of their work.
- The provider did not provide fundamental requirements of their registration such as the display of inspection ratings and submitting statutory notifications to the CQC.
- There was limited evidence that the practice engaged with other practices and stakeholders to improve.

Leadership capacity and capability

Leaders could not 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.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	partial
Explanation of any answers and additional evidence: • Following the previous inspection in January 2020, there was no evidence that the practice had produced an Action Plan to address our concerns, nor was there any evidence that a team approach had been taken in making improvements. We were told a management consultant had	

provided support to help the practice address the findings of the last inspection in the absence of a practice manager between March to August 2020. We were informed that management discussions had taken place, however the practice could not provide any evidence of this. On the morning of our inspection, we received an anonymous 'Business Consultancy Statement'. This two-page document dated 21 April 2021 provided no assurance that the practice had taken an effective approach in tackling previous highlighted concerns.

- The practice manager had worked at the practice, initially as the reception lead from July 2020, and then as the practice manager from January 2021. They were the longest serving member of the substantive team. They were receiving some support and mentorship from a locally based practice manager.
- We saw limited evidence of leadership from the GP. As a single-handed GP, the provider was the designated lead for a number of areas including child and adult safeguarding and infection control. Due to the absence of substantive nursing staff, GPs also had to lead in areas including long-term condition management. The single-handed GP worked in the circumcision clinic for two mornings each week, and also provided three sessions at the local hospital on a weekly basis as a GP with a special interest (GPwSI) in cardiovascular disease/ lipids/hypertension. Therefore, the GP did not have enough capacity to effectively undertake all the responsibilities required of them, compounded by not having any directly employed clinicians.
- The practice did not have a formal succession plan in place, although some consideration had been given to long-term locum GPs at the practice being able to continue the service in the event that the single-handed GP could no longer.
- We observed that the management arrangements with the practice manager and assistant practice manager was having some impact in terms of systems being developed. However, there was considerably more work required to ensure the practice could demonstrate compliance with fundamental standards.

Vision and strategy

The practice did not have a clear vision that was supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	N
There was a realistic strategy to achieve their priorities.	N
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	N

Explanation of any answers and additional evidence:

- The practice website included a mission statement which was not reflective of the service we inspected.
- We were told there was no strategy or vision and a set of values, but it was hoped these would be developed with the new team in the future.
- The practice failed in identifying their key priorities to ensure they could respond to patients' needs, and to comply with fundamental standards of care.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	N
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.	partial
There were systems to ensure compliance with the requirements of the duty of candour.	partial
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's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	N

Explanation of any answers and additional evidence:

- We asked the practice to provide a policy of dealing with poor performance but this was not provided.
- Whilst we found that well-being of staff was accounted for, the practice had not acted on issues to ensure that they were kept safe, for example, failure to act on fire and health and safety audit findings, staff immunisation records, and safe recruitment procedures.
- Staff interviews demonstrated that were not conversant with regards the duty of candour, although we did see an incident involving a patient in which they received an explanation and apology.
- Staff told us that the practice was a good place to work and that team members were mutually supportive. Non-clinical staff told us they were well supported by the practice manager and clinicians. The practice manager had an 'open-door' policy and was accessible to staff during the working day.
- During COVID, staff have been supported with remote working when required.
- We saw limited evidence of staff having completed equality and diversity training.
- A member of staff told us that if patients spoke with them and were unhappy, this would be recorded in their notes. We also saw what could be deemed as a derogatory statement in reference to a patient in a message on the mobile app group. Both could be deemed as potentially discriminatory practice.

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

Source	Feedback
Practice staff	Staff told us they enjoyed their work and felt well supported.
Locum staff	A locum told us it was a relaxed atmosphere to work in, and staff were friendly and supportive. They said the new team were committed to making a change.

	Team building had been considered by arranging a staff lunch session, but this had to be postponed due to COVID. They told us the practice worked at a much slower pace than where they normally worked.
Locum staff	Another locum told us they felt well supported and that it was a friendly practice team.

Governance arrangements

The overall governance arrangements were ineffective.

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

Explanation of any answers and additional evidence:

- We found a lack of oversight in the clinical and managerial leadership and governance systems. This resulted in issues not being identified or adequately managed with the potential to impact upon the delivery of safe and effective care. For example, we would expect to see effective systems and processes to assess and continually monitor the service which reflects the changing needs of people who use it. An effective system should be overseen by senior members of the practice and involve all staff.

- Practice staff had access to a range of policies. However, we reviewed a sample of these and found they did not always contain accurate or up to date information. The policies appeared to be generic and had not always been customised to reflect the arrangements within the practice.

- We did not find that locum clinicians or other staff received effective oversight to provide assurances on their work. The lead GP informed us he did the majority of the repeat prescription requests and would review the locum GP consultations as part of this. However, there was no audit or other evidence to support this. We were not informed how the practice received assurances on the work undertaken by locum nurses.

- We saw the mobile app used within the practice was being used by locum GPs to discuss patients – whilst these were anonymised, the level of information was quite detailed. This information was not recorded in the patients' notes. This could lead to gaps in records and a lack of rationale for decision making. The practice also needed to consider governance arrangments for this including how they would deal with any freedom of information requests, if patient related details were recorded on this system.

- There was no established programme of meetings. There were no clinical meetings or multi-disciplinary team meetings in place. We were told that staff communicated by three different mobile app groups to share documents, updates and queries. Emails were also used to communicate between staff. As five locums worked on site during the week on different days and at different times, it was difficult to get everyone together for a meeting. However, this also made it more important to share information effectively and we were not assured of this, and we saw that arrangements were disjointed and staff worked in isolation.

- We were told that staff meetings took place on a monthly basis but at the time of our inspection in April 2021, we saw the most recent one had taken place in January 2021. We were told this was due to COVID vaccination deliveries. There were some brief minutes of this meeting, and the agenda did not reflect the content of the minutes. The attendees were listed as the lead GP and some members of the administration team. Locum staff told us they did not receive minutes. We queried one of the attendees at the staff meeting and were told this was an external person that the lead GP who had been asked to come in and talk with staff. The minutes indicated they had held 1-1 meetings with staff beforehand and we had concerns about why this took place, and how this individual may have been privy to confidential information.

- We were told the team also held informal huddles to share information. We saw one set of brief notes of a huddle discussion in January 2021 involving the GP and four members of the administrative team.

- There were no staff appraisals. However, the longest serving member of staff (other than the long-term locum GPs) had only been in post 8 months. We were told that appraisals would commence in the near future. As the non-clinical team (including the healthcare assistant) were new, we did not see any evidence of how their competency was being assessed in terms of undertaking key aspects of their role.

- Staff training and induction records were limited. However, it is acknowledged that most staff had been in post less than a year to have completed all the required training, although we would have expected to see that most of their mandatory training and those associated with key duties of their role were prioritized.

- As the PCN pharmacists undertook a lot of work around repeat prescribing and medicine reviews, we were unclear how the practice checked their prescribing competencies.

- We found limited documented evidence to demonstrate compliance with fundamental standards of care throughout the inspection process.

- The infection control audit undertaken by the CCG Infection Prevention and Control Nurse in October 2020 indicated that the data logger for the vaccine fridge was not being used. Following the audit, the practice had implemented a system to monitor their three vaccine fridges. We saw that checks were recorded manually daily and the data logger was downloaded weekly, or when a problem with temperature ranges was identified. Vaccine fridges were well maintained. This was an example where the new management team had taken effective action to address an identified concern.

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

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

There was a quality improvement programme in place.	partial
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	N
When considering service developments or changes, the impact on quality and sustainability was assessed.	N/A

Explanation of any answers and additional evidence:

- The practice was unable to demonstrate that there were effective systems in place to manage and mitigate risks. The practice was mostly unable to demonstrate that they were aware of the areas of risk we identified.
- There was no action plan in place from the last inspection or a co-ordinated approach to engage with staff to respond to our concerns. Therefore, we could not be assured that progress had been made on the areas of risk identified at the previous inspection.
- Quality improvement programmes were limited.
- Prescribing audits were being done by the PCN pharmacists and these have identified changes to practice that GPs were then advised about.

The practice mostly 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.	N
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.	N
There were recovery plans in place to manage backlogs of activity and delays to treatment.	N
Changes had been made to infection control arrangements to protect staff and patients using the service.	partial
Staff were supported to work remotely where applicable.	Y

Explanation of any answers and additional evidence:

- We were told that the lead GP offered telephone consultations three days a week from 7.30-8am as part of extended opening hours, commissioned through the CCG. On each day, a locum GP provided a two-hour session of which 1.5 hours were for patient consultations. On the week of our inspection, the practice had undertaken 61 telephone consultations with patients and one face-to-face appointment. This equated to each locum doing 10 patient appointments per day, with 4 extra appointment each day for the three extended opening hours sessions. When no

appointments were available, patients were re-directed to one of three local hubs which provided appointments from 8am to 8pm seven days a week.

- The practice told us they were monitoring the appointments usage during COVID, but they felt there was sufficient capacity to meet need.

- Nursing appointments were limited to Thursdays, and as some sessions were dedicated to COVID vaccinations at the time of our inspection, there was very little nursing capacity available to patients.

- We were informed that the needs of vulnerable people (including those who might be digitally excluded) had not been considered in relation to access throughout the pandemic. We were told that if patients required an appointment, they would contact the surgery as usual.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	N
Performance information was used to hold staff and management to account.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
Staff whose responsibilities included making statutory notifications understood what this entails.	N

Explanation of any answers and additional evidence:

- The inspection was announced three weeks in advance of the site visit. Throughout the pre-inspection period, evidence was very difficult to obtain and this did not seem to be readily available.

- We saw no evidence that the practice used data to improve performance. Whilst a number of performance issues had been highlighted at the previous inspection, the practice failed to demonstrate that they had considered this and taken action to improve.

- At our previous inspection in 2020 we highlighted that the practice was unaware of what issues they needed to inform the CQC about via a statutory notification. At this inspection in April 2021, we found that the practice was not adhering to fundamental requirements of their registration. For example, managers remained unaware of the CQC notification process, and the provider's Statement of Purpose (SoP) was out of date and had last been last updated in 2018. The practice was not displaying the rating of their last inspection.

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.	N/A
Explanation of any answers and additional evidence:	

Engagement with patients, the public, staff and external partners

The practice did not involve 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.	N
The practice had an active Patient Participation Group (PPG).	N
Staff views were reflected in the planning and delivery of services.	N
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	N

Explanation of any answers and additional evidence:

- The practice had not undertaken any patient surveys or explored other ways to review patient feedback since the last inspection. This had been difficult due to the COVID-19 pandemic but the practice told us they were hoping to reintroduce patient surveys in the future.
- We saw that 17 postings had been made on the NHS Choices website. Apart from some negative postings towards the latter part of 2019, the comments were extremely positive and indicated that patients were happy with the service they received. We saw that less favourable comments had been made about the practice and the circumcision service on other feedback websites.
- We were told that informal 'huddles' were held with staff on duty on that particular day. Formal staff meetings were planned to be held on a monthly basis but the last minutes indicated this took place in January 2021.
- Staff were not involved in the approach to address the concerns from our previous inspection.
- Our previous inspection highlighted the potential of becoming a closed culture. This was reinforced by the inspection in April 2021, and the practice was not found to be proactive at working with stakeholders.
- Following the publication of the previous inspection report in March 2020, the practice was required to display their ratings on their website and in a visible part of the practice for the public to see, this is usually in the waiting area, On announcing the inspection, the report was not visible on the website. This had been amended by the time of our visit in April 2021, but the poster

highlighting the ratings was not displayed. This is a breach of regulations. Following the visit, the practice made sure the ratings summary was displayed.

Feedback from Patient Participation Group.

Feedback
• The PPG had ceased to function, and we were told that interest had dwindled during the COVID-19 pandemic. However, at our previous inspection in January 2020, the patient participation group had not met for at least 12 months, and the practice told us that they had plans to energise the PPG with digital forums to encourage as many people to contribute as possible. This had not evolved since that time but we were informed that a group of approximately seven patients had been identified to help reinstate an active PPG, but no firm arrangements were in place at the time of our inspection.

Any additional evidence
• At our previous inspection in January 2020 it was highlighted that the practice had identified a low number of patients (64) who were carers. This was identified as an area in which the practice should improve. At this inspection in April 2021, the practice had only 11 patients identified as carers which equates to 0.1% of their registered patients. We saw limited evidence of how carers were being identified in order to provide them with information and support.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	N
Learning was shared effectively and used to make improvements.	N
Explanation of any answers and additional evidence: • We found that the practice team needed to undertake further work to embed systems to facilitate a programme of active learning and development.	

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.
- **PHE**: Public Health England.
- **QOF**: Quality and Outcomes Framework.
- **STAR-PU**: Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ***PCA**: Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see GMS QOF Framework).
- ‰ = per thousand.