

Care Quality Commission

Inspection Evidence Table

Dr Gulzar Ahmed (1-520580465)

Inspection date: 30 October 2019

Date of data download: 31 October 2019

Overall rating: Requires Improvement

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Safe Rating: Requires Improvement

The practice was rated as requires improvement for providing safe services because the practice could not demonstrate that:

- Safeguarding training had been completed by all staff relevant to their role.
- Recruitment records were maintained in accordance with regulations.
- Arrangements in relation to infection control mitigated the risk of spread of infection.
- Immunisation status of all staff was not maintained in line with current guidance.

Safety systems and processes

There were gaps in the 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.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Partial ¹
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial ²
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social	Yes

Safeguarding	Y/N/Partial
workers to support and protect adults and children at risk of significant harm.	
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. We saw that the lead GP and two long-term locums GPs had undertaken safeguarding children and safeguarding adult training level 3. However, the practice could not demonstrate from the records it maintained that all staff had completed training relevant to their role. After the inspection the practice sent additional evidence of safeguarding training, although some of this had been undertaken after the inspection. The practice has not been able to demonstrate that a long-term locum GP has undertaken safeguarding children and safeguarding adult training and all staff have been trained to a level appropriate to their role. For example, the practice could only provide evidence of safeguarding adult level 1 training for a healthcare assistant. 2. On the day of the inspection the practice could not demonstrate from the records it maintained evidence of an appropriate Disclosure and Barring Service (DBS) certificate in place for all their clinical staff. After the inspection the practice sent additional evidence. However, we noted an enhanced DBS check sent for a long-term locum GP, which had been obtained for a previous role in 2014, had only requested a child workforce check. An adults' barred list information had not been requested and was not sufficient, therefore, for the role of GP. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial ¹
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Partial ²
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes ³
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. The practice maintained a list of employment documentation, but we saw there were gaps in the records and the practice could not demonstrate that all appropriate checks had been carried out at the time of recruitment. We specifically reviewed employment records for three regular locum GPs, two practice nurses, a healthcare assistant and two non-clinical staff and found gaps which included evidence of CVs, interview notes, references, DBS checks and inclusion on the national performers list. In addition, we saw none of the long-term locum GPs had been issued with a locum practice agreement. After the inspection the practice sent additional evidence, but we found there were still gaps in their records to demonstrate safe recruitment. For example, an appropriate DBS check in place for a GP and a practice nurse. 2. The practice maintained a record of staff immunisation status, but we found this was incomplete and not in line with current guidance in the 'Immunisation Against Infectious Diseases' (Green Book, Chapter 12). 3. The registered manager told us the registration status of clinical staff was checked at the time of recruitment and then on a quarterly basis. We saw evidence that this had been documented. 	

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: 22.10.2019	Yes
There was a record of equipment calibration. Date of last calibration: 22.10.2019	Yes

There were risk assessments for any storage of hazardous substances for example, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire alarm maintenance checks. Date of last check: 30.04.2019	Yes
There was a record of fire extinguisher checks. Date of last check: 30.04.2019	Yes
There was a log of fire drills. Date of last drill: 07.06.2019 (undertaken six monthly)	Yes
There was a record of fire alarm checks. Date of last check: 25.10.19 (undertaken weekly)	Yes
There was a record of fire training for staff. Date of last training: Variable (undertaken on e-learning training platform)	Partial ¹
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 28.10.2019	Yes
Actions from fire risk assessment were identified and completed.	No ²
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. On the day of the inspection the practice could not demonstrate that all clinical and non-clinical staff had undertaken fire awareness training in line with guidance. After the inspection the practice sent additional evidence that staff had undertaken training, but we saw that some had been undertaken after the inspection on the practice's e-learning training platform. 2. A formal fire risk assessment had been undertaken immediately prior to our inspection on 28 October 2019 by an external company. At the time of our inspection the practice had not received the formal report and action plan. After the inspection the provider sent a copy of the fire risk assessment which include a remedial action plan of six action points with a timeframe for completion. The practice told us they were addressing the action points. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 12.12.2018	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 28.10.2019	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • A formal health and safety risk assessment had been undertaken immediately prior to our inspection on 28 October 2019 by an external company. At the time of our inspection the practice had not received the formal report and action plan. After the inspection the provider sent a copy of the health and safety risk assessment which include a remedial action plan of one action point with a timeframe for completion. The practice told us they were addressing the action point. • An asbestos fibre identification report had been undertaken immediately prior to our inspection on 28 October 2019 by an external company. After the inspection the provider sent a copy of the report and we saw that no asbestos had been identified from samples taken. 	

- A formal legionella risk assessment had been undertaken immediately prior to our inspection on 28 October 2019 by an external company. At the time of our inspection the practice had not received the formal report and action plan. After the inspection the provider sent a copy of the risk assessment which include a remedial action plan of four action points with a timeframe for completion. The practice told us they were addressing the action points.
- The practice manager was the nominated responsible person for legionella management at the practice. At the time of the inspection they had not undertaken any legionella awareness training. This was also highlighted as a remedial action in the legionella risk assessment. After the inspection the practice provided evidence that a one-hour 'legionnaires disease' training module had been undertaken by the responsible person on their on-line training platform. We do not know the content of the training module so cannot comment if this meets the requirements of legionella awareness training noted in the risk assessment.
- The practice told us that monthly hot and cold-water temperature testing was undertaken but was unable to provide a record of this.
- We saw evidence of a gas safety certificate dated 25 October 2019. The practice told us an electrical fixed installation condition report had been undertaken by the landlord but were unable to provide this on the day of the inspection of after the inspection.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were partially met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes ¹
Staff had received effective training on infection prevention and control.	Partial ²
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 15.08.2019	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Partial ^{3,4}
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes

Explanation of any answers and additional evidence:

1. The practice had an Infection Prevention and Control (IPC) policy and staff we spoke with knew how to access the policy. However, we found that the practice was not following some aspects of their own policy. For example, not all clinical staff we spoke with were aware of the procedure for managing a sharps injury, there was no cleaning schedule and record for cleaning for the ear irrigator or nebulizer, and we observed that clinical staff did not have access to all the appropriate colour-coded sharps containers required for the range of medicines administered at the practice.
2. On the day of the inspection the practice could not demonstrate that all staff had undertaken IPC training. After the inspection the practice sent evidence of staff training but we saw some of this had been undertaken after the inspection. In addition, we saw that the IPC lead had not undertaken any training for the lead role that included specific IPC knowledge in line with the Hygiene Code which identified specific primary care IPC responsibilities for this role such as how to mitigate the risk of healthcare acquired infection.
3. We saw that the IPC audit undertaken in August 2019 had indicated that cleaning equipment was appropriately stored. However, on the day of the inspection we observed the store room to be cluttered with inadequate storage of segregation of cleaning equipment which posed a risk of cross-contamination. There was a cleaning schedule on the door of each clinical room but there was no overall cleaning schedule with frequency completed and signed by the cleaner.

4. The IPC audit action plan had referenced compliance with the practice's uniform policy, specifically the bare below the elbow dress code. However, on the day of the inspection we observed some clinicians were not bare below the elbow whilst undertaking clinical sessions.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes ¹
There was an effective induction system for temporary staff tailored to their role.	Yes ²
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
Explanation of any answers and additional evidence: <ol style="list-style-type: none"> The lead GP undertook nine clinical sessions per week and told us their absence was covered by a locum GP. The administrative staff at the practice told us that they would provide cover for each other during staff absences and busy periods. We saw that there were clinical and non-clinical induction schedules and a GP locum pack available. 	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Partial ¹
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes ²
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-	Yes

clinical staff.	
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes
Explanation of any answers and additional evidence:	
<p>1. We saw that the practice had a system in place whereby the healthcare assistant would document influenza immunisations and B12 injections given by the lead GP in the clinical system using their NHS smart card. We saw that there was no indication in summary that the GP had administered the medicine, which left an inaccurate audit trail in the patient's clinical notes as to who had administered the medicines. When we raised this with the practice on the inspection they told us that this would be stopped immediately.</p> <p>2. The practice told us that new patient records were predominantly transferred via GP2GP (the electronic transfer of patients' health records between practices). The practice told us other notes were summarised by the healthcare assistant in line with their summarising protocol. The practice did not have any formal audit process in place to monitor that this process was undertaken in line with the protocol.</p>	

Appropriate and safe use of medicines

There were systems in place 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) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.68	0.52	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2018 to 30/09/2019) (NHSBSA)	9.5%	9.5%	8.5%	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 (01/04/2019 to 30/09/2019) (NHSBSA)	6.75	5.72	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	4.07	1.23	2.08	Tending towards variation (negative)

Any additional evidence or comments

The practice was aware that their non-steroidal anti-inflammatory drugs (NSAIDs) prescribing was higher than local and national averages. The practice told us that the medicines optimisation team undertook a weekly session and were working with the practice on the reduction of NSAIDs prescribing. At the time of our inspection validated prescribing data for the period 1 January to 30 June 2019 showed the practice prescribing for NSAIDs was 4.30 (CCG 1.26; England 2.08). Validated data available since the inspection for the period to 30 September 2019 showed a reduction to 4.07 (CCG 1.23; England 2.08). In addition, additional unvalidated data provided by the medicine optimisation team on current achievement suggested a further reduction in prescribing.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial ¹
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.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance	Yes

Medicines management	Y/N/Partial
to ensure they remained safe and effective.	
Explanation of any answers and additional evidence: 1. We saw that one of the practice nurses who worked under the direction of the available patient group directions (PGDs) had not signed them.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	3
Number of events that required action:	3
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There was an incident policy in place, which was accessible to staff. • We saw that incidents and outcomes were discussed in clinical meetings. 	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice demonstrated their system to receive and action patient safety alerts and we saw evidence of patient searches and outcomes for recent alerts. We saw that patient safety alerts were discussed in clinical meetings, which were minuted. 	

Effective

Rating: Requires Improvement

The practice was rated as requires improvement for providing effective services because:

- Some long-term condition patient outcomes, childhood immunisations and cervical screening uptake were below national averages.
- Some of the staff had not completed appropriate core training in line with guidance and practice policy.
- There was no system in place to undertake any formal appraisal or review of their long-term locum GPs or locum practice nurse.

Although there was evidence of some good practice for the population groups, these areas affected all patients, so we rated all population groups as requires improvement.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	N/A

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>	2.72	0.88	0.74	Significant Variation (negative)

Any additional evidence or comments

The practice was aware that their hypnotic prescribing was higher than local and national averages. The practice hosted a weekly mental health support worker clinic and felt this may impact on their performance. The practice told us that the medicines optimisation team undertook a weekly session and were working with the practice on the reduction of hypnotic prescribing. Unvalidated data provided by the medicine optimisation team on current achievement suggested a reduction in prescribing.

Older people

Population group rating: Requires Improvement

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and

communication needs.

- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Patients with suspected hypertension were offered and referred for ambulatory blood pressure monitoring.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	69.3%	79.6%	79.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	12.8% (30)	9.3%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	79.1%	77.8%	78.1%	No statistical variation
Exception rate (number of exceptions).	8.5% (20)	8.7%	9.4%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	72.1%	79.8%	81.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	8.5% (20)	10.1%	12.7%	N/A

We saw that outcomes for patients for some diabetes indicators were lower than England averages. We reviewed previous Quality and Outcomes Framework (QOF) data and saw that achievement had been lower than national averages over a period of time. For example:

- The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months:
 - 2015: 53.4% (England average 77.5%)
 - 2016: 68.7% (England average 78%)
 - 2017: 59.7% (England average 79.5%)
 - 2018: 76.8% (England average 78.8%)
 - 2019: 69.3% (England average 79.3%)
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less:
 - 2015: 61.6% (England average 80.5%)
 - 2016: 76.4% (England average 80.2%)
 - 2017: 65.7% (England average 83.2%)
 - 2018: 83.2% (England average 80.1%)
 - 2019: 72.1% (England average 81.3%)

The practice participated in the Clinical Commissioning Group's Whole Systems Integrated Care (WSIC) Dashboard for diabetes. We saw that practices were measured against nine key care processes over a 15-month period which included the management of HbA1c, blood pressure and cholesterol. Data provided showed the practice was working towards making some potential improvements in the management of patients with diabetes.

Other 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, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	79.3%	75.6%	75.9%	No statistical variation
Exception rate (number of exceptions).	1.5% (2)	7.6%	7.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	94.6%	88.2%	89.6%	No statistical variation
Exception rate (number of exceptions).	5.1% (2)	13.7%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is	79.9%	79.5%	83.0%	No statistical variation

150/90mmHg or less (01/04/2018 to 31/03/2019) (QOF)				
Exception rate (number of exceptions).	2.4% (9)	3.8%	4.0%	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 (01/04/2018 to 31/03/2019) (QOF)	76.0%	86.5%	91.1%	Tending towards variation (negative)
Exception rate (number of exceptions).	7.4% (2)	5.3%	5.9%	N/A

Any additional evidence or comments

We saw that outcomes in those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of two or more, the percentage of patients who are currently treated with anti-coagulation drug therapy was below national averages. We reviewed previous Quality and Outcomes Framework (QOF) data and saw that achievement had been lower than national averages over a period of time. For example:

- 2016: 75% (England average 86.7%)
- 2017: 78.3% (England average 88.4%)
- 2018: 75% (England average 87.9%)
- 2019: 76% (England average 86.5%)

The lead GP, when asked about ensuring good clinical outcomes for people at risk of developing cardiovascular disease, was unsure until prompted of QRISK2 (an algorithm for predicting cardiovascular risk and the risk of a person developing cardiovascular disease over the next 10 years).

Families, children and young people

Population group rating: Requires Improvement

Findings

- The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of four childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- 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 practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

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,	12	16	75.0%	Below 80% uptake

Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)				
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	18	25	72.0%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	20	25	80.0%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	19	25	76.0%	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

We saw that the practice's childhood immunisation outcomes had been consistently below the WHO target of 95% over a period of time. For example:

- The percentage of children aged one 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):
 - 2015: 88%
 - 2016: 85.7%
 - 2017: 84.6%
 - 2018: 82.6%
 - 2019: 76%
- The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster):
 - 2015: 82.7%
 - 2016: 84%
 - 2017: 52.7%
 - 2018: 64.2%
 - 2019: 72%
- 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):
 - 2015: 86.2%
 - 2016: 80%

- 2017: 43.48%
- 2018: 85.71%
- 2019: 80%

- The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR):

- 2015: 82.7%
- 2016: 72%
- 2017: 56.5%
- 2018: 78.5%
- 2019: 76%

The practice was aware that patient outcomes were low and felt this was, in part, due to a transient population and a difficult to engage patient population. The practice told us they actively followed-up on patients who did not attend for immunisations.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- Patient outcomes for cervical cancer screening was below target.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

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) (01/04/2017 to 31/03/2018) (Public Health England)	51.7%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	53.6%	54.1%	72.1%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	31.8%	37.8%	57.3%	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. (01/04/2017 to 31/03/2018) (PHE)	57.1%	59.7%	69.3%	N/A

Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) ^(PHE)	30.0%	53.5%	51.9%	No statistical variation
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Any additional evidence or comments

We saw that the practice's cervical screening uptake had been consistently below target overtime: 2016 59%; 2017 53.1% and 2018 51.7%. The practice was aware that patient outcomes were low and felt this was, in part, due to a transient population and a difficult to engage patient population. The practice told us they now planned to actively engage with the local community, stakeholders and charities to address this.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

- The practice 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.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice 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.
- Patients with poor mental health, including dementia, were referred to appropriate services.

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 (01/04/2018 to	89.7%	88.9%	89.4%	No statistical variation

31/03/2019) (QOF)				
Exception rate (number of exceptions).	5.6% (4)	10.3%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	91.2%	91.4%	90.2%	No statistical variation
Exception rate (number of exceptions).	5.6% (4)	7.3%	10.1%	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 (01/04/2018 to 31/03/2019) (QOF)	84.6%	85.3%	83.6%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	7.8%	6.7%	N/A

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	543.8	No Data	539.2
Overall QOF score (as a percentage of maximum)	97.3%	No Data	96.4%
Overall QOF exception reporting (all domains)	8.5%	No Data	No Data

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a programme of quality improvement and used information about care and treatment to make improvements.	Yes
Quality improvement activity was targeted at the areas where there were concerns.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had a programme of quality improvement which included prescribing audits undertaken with the medicine optimisation team and practice-initiated audits. The practice provided three two-cycle audits undertaken in the past two years which included improving dementia prevalence, warfarin and methotrexate prescribing. 	

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

The practice used information about care and treatment to make improvements. For example, one audit reviewed warfarin prescribing to ensure all patients on warfarin had a documented international normalised ratio (INR), a laboratory measurement of how long it takes blood to form a clot, in their medical records and that warfarin was prescribed on an acute and not repeat prescription template.

The first cycle audit in March 2019 showed:

- 85% of patients had an INR recorded in their medical record.
- 80% of patients were issued a prescription on an acute template.

The second-cycle audit in September 2019 showed:

- 100% of patients had an INR recorded in their medical record.
- 100% of patients were issued a prescription on an acute template.

Effective staffing

The practice was unable to demonstrate that all 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. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Partial ¹
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial ²
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.	Yes
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. The practice told us that it had identified basic life support, infection prevention and control, fire safety, safeguarding children and adults, mental capacity act, equality and diversity, prevent, chaperone, sepsis, information governance, health and safety, moving and handling, conflict resolution and privacy and dignity as core training for all their staff. However, the practice could not demonstrate that all clinical and non-clinical staff had undertaken the training. For example, safeguarding adult and children, mental capacity act and infection prevention and control training for a long-term locum GP. In addition, we saw that the practice had basic life support training on an 18-month update frequency for clinical staff and 36-month frequency schedule for non-clinical staff which was not in line with recognised guidance. 2. We saw evidence that substantive staff had an annual appraisal. However, the practice did not have a system in place to undertake any formal appraisal or review of their long-term locum GPs or locum practice nurse. 	

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A

Helping patients to live healthier lives

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

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

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	94.8%	95.5%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.5% (3)	1.2%	0.8%	N/A

Consent to care and treatment

The practice always obtained in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	No
Policies for any online services offered were in line with national guidance.	N/A
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had identified Mental Capacity Act (MCA) training as part of its core training schedule for clinical staff. However, on the day of the inspection the practice could not demonstrate that all clinical staff had undertaken the training. After the inspection the practice sent additional evidence of training certificates. However, we noted that this had been undertaken after the inspection on their on-line training platform. The practice provided evidence through a review of patient medical records that consent had been sought and recorded. However, there was no formal process in place to monitor that consent was sought appropriately, for example, through an audit. 	

Well-led

Rating: Requires Improvement

The practice is rated as requires improvement for providing well-led services because:

- The provider had not ensured that effective systems and processes were in place to ensure good governance in accordance with the fundamental standards of care. In particular, governance systems had failed to identify gaps in relation to safe recruitment, infection prevention and control and staff core training.**
- The provider did not have a formal written strategy.**

Leadership capacity and capability

Although there was compassionate and inclusive leadership at all levels, there were gaps in management oversight which impacted on the practice's capacity to deliver consistent high-quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	No
They had identified the actions necessary to address these challenges.	No
Staff reported that leaders were visible and approachable.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We found a lack of effective management oversight and some governance systems and processes were not sufficiently embedded to ensure consistent high-quality care. 	

Vision and strategy

The practice had a clear vision, but it was not supported by a credible strategy. Deficiencies in governance and oversight undermined the practice's ability to achieve their vision.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes ¹
There was a realistic strategy to achieve their priorities.	No ²
Progress against delivery of the strategy was monitored.	No ³
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial ⁴
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. The practice told us that their mission was, 'to deliver the highest level of medical care to our local resident population; deliver health care in a flexible and innovative way to meet patient choice and to reflect changing political and economic circumstances. To ensure patients are always at the heart of everything we do: ensuring patients are treated with dignity, respect, empathy and sympathy.' 2. Staff we spoke with told us that the management team discussed in practice meetings any change to services provided by the practice and future developments. However, there was no formal up-to-date strategy developed in collaboration with staff, patients and external partners. For example, we discussed succession planning and practice sustainability in relation to the lead GP who undertook nine clinical sessions per week and provided out-of-hours care for the patient population from 6.30pm to midnight 365 days a year. After the inspection the practice told us that the lead GP planned to opt-out of providing out-of-hours care. In addition, they told us they planned to increase the sessions undertaken by long-term locums to enable to lead GP to reduce their clinical sessions. However, this had not been formalised in a strategy with projected timescales. 3. We found that there was a lack of management oversight in key areas relating to monitoring and management of risk to patient safety which had the ability to compromise the quality of care provided by the practice and impact on its vision, values and any proposed strategy. 4. Staff we spoke with were aware of the practice's vision and values but were unaware of a formal written strategy. 	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes ¹
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes

The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes ²
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Partial ³
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. We saw that the practice had included health and safety, moving and handling training and conflict resolution to support staff safety and well-being as part of their core training schedule. 2. The practice had duty of candour and whistleblowing policies in place, which were accessible to staff. 3. We saw that the practice had identified equality and diversity training as part of their core training schedule but not all staff had completed the training at the time of our inspection. 	

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

Source	Feedback
Staff interviews	Staff told us they felt supported by the management team and they were approachable.

Governance arrangements

Although there were clear responsibilities, roles and systems of accountability to support good governance we found gaps in its management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We found gaps in management oversight and some systems and processes were not sufficiently embedded to ensure good governance. This was demonstrated in gaps and inconsistencies in the management of safe recruitment, infection prevention and control and staff core training. • The practice had a meeting structure which included regular staff, clinical and multidisciplinary meetings. We saw that all meetings were minuted and minutes were available for staff. The practice also engaged with practices in its locality as part of local initiatives, for example the Primary Care Network (PCN). • The practice had nominated staff into designated lead roles, for example safeguarding, infection prevention and control and complaints. • There were practice-specific policies including, child and adult safeguarding, infection and prevention control and significant events. All staff we spoke with knew how to access the policies. 	

Managing risks, issues and performance

Although there were processes in place for managing risks, issues and

performance we found gaps in its management.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Yes
There was a programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We were not assured that the practice's systems in place to effectively manage risk and performance were regularly reviewed as we found gaps in some processes. 	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We did not speak with any patients during the inspection. However, as part of our inspection process, we asked for CQC comments cards to be completed by patients during the two weeks prior to our inspection. Thirty comment cards were received, all of which were positive, and described the practice as very good and staff were kind and caring. The practice sought patient feedback through the NHS Friends and Family Test (FFT). Results for the period April to October 2019, based on 49 responses, showed that 94% of patients would 	

be extremely likely or likely to recommend the service.

- We reviewed the National GP Patient Survey for the period 1 January 2019 to 31 March 2019. We saw that 454 surveys had been sent out and 70 were returned, which was a response rate of 15.4% and 2.03% of the practice population. We saw that the outcomes in relation to the practice being caring and responsive were, for the majority, statistically comparable with CCG and England averages. For example:

Caring

- 76.8% of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (CCG average 85.9%; England average 88.9%).
- 87.4% of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (CCG average 92%; England average 95.5%).
- 82% of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (CCG average 81.5; England average 87.4%).
- 94.9% of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (CCG average 90.5%; England average 93.4%).

Responsive

- 76.5% 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 (CCG average 81%; England average 68.3%).
- 96.2% of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (CCG average 91.3%; England average 94.5%).
- 57.6% of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (CCG average 60.6%; England average 64.7%).
- 54.4% of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (CCG average 63.5%; England average 73.6%).

Feedback from Patient Participation Group.

Feedback

We spoke with the chairperson of the Patient Participation Group (PPG) after the inspection who told us the PPG had approximately five members and met quarterly. They told us the practice engaged with the PPG and attended meetings. We saw that meetings were minuted and we reviewed the minutes of the June and October 2019 meetings.

Continuous improvement and innovation

There were some systems and processes in place for learning, continuous improvement and innovation.

	Y/N/Partial
There was a focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	

- The practice engaged with the CCG and neighbouring practices in local current and future initiatives which included the Primary Care Network (an approach to strengthening and redesigning primary care to focus on local population needs and provide care closer to patients' homes).
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

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.