

Care Quality Commission

Inspection Evidence Table

Dr Bhalla's and Partners (1-6482641034)

Inspection date: 6 October 2022

Date of data download: 24 August 2022

Overall rating: Good

Safe

Rating: Good

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice had safeguarding leads for both adults and children and policies in place to support staff in the event of a safeguarding concern. Staff we spoke with knew what to do if they had any concerns about a patient.All staff had completed the required level of safeguarding training relevant to their role and were clear on the procedure to follow if they had a safeguarding concern.The practice held safeguarding registers and discussed their most vulnerable patients at regular safeguarding meetings.Patient records we reviewed showed that they had been appropriately coded where safeguarding concerns had been identified.	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> Clinical system alerts were used to identify patients who were at risk of harm or abuse. The system also identified other close contacts so that staff were aware of other family members who could potentially be at risk. Records we examined showed that all staff who undertook chaperoning duties had received training and been DBS checked. We reviewed meeting minutes and found evidence that safeguarding concerns were discussed in practice and clinical meetings. Clinicians followed up children and young people who were not brought to their appointments both at the practice and for secondary care appointments. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We reviewed four personnel files including clinical and non-clinical staff and found all the appropriate checks had been carried out prior to employment such as references, proof of identity and staff vaccinations in line with relevant guidance. Induction checklists were in place for each staff member tailored to their role. This included locum staff. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 1 September 2022	Y
There was a fire procedure.	Y
Date of fire risk assessment: 17 October 2020 Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff had access to a health and safety policy, which had been reviewed in the last 12 months. The property was managed by NHS property services who had carried out a health and safety and premise risk assessment. The practice had also carried out their own health and safety inspection in July 2022. A water risk assessment had been carried out for the building in March 2002 which included legionella checks and monitoring in place. Calibration checks for equipment was undertaken in September 2022 and testing of portable appliances was undertaken in November 2021 to ensure they were fit for purpose and were in good working order. All staff were up to date with health and safety training. A training matrix was in place to help the management team monitor that all staff training was completed when due. A fire risk assessment had been carried out for the building which was reviewed every two years and there were fire procedures in place and weekly fire alarm testing. There were four appointed fire marshals and a fire drill had been undertaken in September 2022. Training records showed fire safety training had been completed by all staff. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 4 July 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• There was an infection control lead in place and staff had completed infection prevention training relevant to their role. An infection control audit had been carried out in July 2022 and an area identified to de-clutter the reception area had been actioned by the practice.• A hand washing and hygiene protocol was in place and an audit of staff handwashing techniques had been carried out in August 2022. Other policies in place to support infection control included needlestick injury, decontamination, clinical waste protocol and control of substances hazardous to health (COSHH).• We observed the general environment to be clean and tidy with the layout and facilities of the premises in line with COVID-19 guidance for infection prevention and control.• A personal protective equipment (PPE) policy was in place.• Staff we spoke with told us about the systems and processes they followed to ensure clinical specimens were handled safely.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• A rota system was in place to manage staffing and staff worked flexibly and had opportunities for overtime to cover absences.• The practice had a locum pack to support staff working at the practice on a temporary basis.• Systems were in place to ensure emergency medicines and equipment was checked on a regular basis.• All staff had undertaken basic life support, anaphylaxis and sepsis training and understood the procedures to follow when encountering deteriorating or unwell patients.• Reception and administration staff who handled calls to the practice and arranged appointments with the clinical team were aware of potential red flag symptoms. Staff knew when to notify a GP or other clinicians with concerns.	

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. ¹	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Our clinical searches found that clinical records were well maintained, for example history, examination, management plans and safety netting were adequately documented. • There was a system in place to ensure all patient information including documents, laboratory test results and cytology reports were reviewed and actioned in a timely manner. • A sample of referral letters seen for specialist services contained relevant information. • The practice had established systems for monitoring two week wait referrals to ensure patients were seen. 	

Appropriate and safe use of medicines

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

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.76	0.81	0.79	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2021 to 31/03/2022) (NHSBSA)	6.5%	6.2%	8.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022) (NHSBSA)	4.90	5.21	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	109.7‰	138.1‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.68	0.66	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	9.0‰	8.7‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
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. ²	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> • National prescribing data showed the practice prescribing was in line with local and national averages in all categories. • There was a clinical lead in place and the practice carried out audits and clinical reviews of clinician's records to ensure competency standards were maintained. • There was a system and process in place for clinical reviews and our clinical searches showed that most patients had received appropriate medicine reviews. • As part of our inspection we reviewed a sample of patients on Disease-modifying antirheumatic drugs (DMARDs) and high-risk medicines that required regular monitoring due to the risk of side effects. We found that all patients identified had the required monitoring in place. • We reviewed patients on potassium sparing diuretics (a medicine used to treat hypertension, cirrhosis and congestive heart failure) and found three patients were overdue monitoring. Practice staff were taking appropriate action to review these patients. 	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> We reviewed five patients identified as having been prescribed more than 10 prescriptions for benzodiazepines or Z drugs in the past 12 months (these are medicines prescribed for anxiety, sleeping problems, such as insomnia and other disorders). All had appropriate monitoring or had been referred for additional support. There was clinical oversight for all requests to medicine changes and a clear process was in place to demonstrate what actions had been taken. We found that blank prescriptions were kept securely and there was a system in place to monitor usage. Emergency medicines, vaccines and medical equipment were appropriately stored and there were clear monitoring processes in place. There were appropriate arrangements in place for the management of vaccines and for maintaining the cold chain. We saw fridge temperatures were routinely monitored and vaccines reviewed at random were in date and stored appropriately. 	

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.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	Six
Number of events that required action:	Six
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had a significant event monitoring policy and reporting template in place. Staff we spoke with were aware of how to report and record significant events. Significant events were a standing agenda item and we saw evidence that they were discussed at clinical meetings and practice meetings. 	

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

Event	Specific action taken
The fridge seal containing vaccinations was damaged by wear and tear. Staff realised the fault during the monthly fridge cleaning.	The incident was immediately reported to the management team who notified the manufacturers. The fridge was cleaned down and the vaccinations were safely checked and moved to another fridge. The fridge was repaired.
A patient called to cancel their appointment and the incorrect patient was cancelled by the practice.	The practice realised their mistake and all staff were reminded of the process to check patients full details when making and cancelling appointments.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had a system in place for the recording and acting on safety alerts. These were received by the management team and reviewed with the appropriate staff. All safety alerts were discussed in clinical meetings and appropriate action was taken. • We looked at the action clinical staff had taken in response to an alert relating to patients prescribed a specific medicine used to lower blood glucose (sugar) levels in patients with type 2 diabetes. We checked whether patients had been informed of the rare but serious and potentially life threatening risks associated with these medicines and also made aware of the urgent action they should take if they experienced the identified symptoms. We found that appropriate action had been taken. 	

Effective

Rating: Good

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. ³	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Clinical staff kept up to date in their clinical practice through local networks and evidence-based guidance such as those from the National Institute for Health and Care Excellence (NICE).• Provider policies and procedures were in place which promoted evidence-based practice.• Our clinical system reviews found appropriate follow up, care and treatment was provided in the management of patients with or at risk of long-term conditions.	

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- 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.
- All patients with a learning disability were offered an annual health check. During the last 12 months the practice had carried out 96% of learning disability reviews.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. During the last 12 months the practice had completed 82% of mental health reviews.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

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.
- Our clinical searches included a review of patients with the potential of a missed diagnosis of diabetes based on blood test results. We looked at the records for five patients and found all were being appropriately monitored.
- We reviewed the records for five patients with diabetic retinopathy (a complication of diabetes) and all patients were up to date with a follow up and monitoring.
- We randomly reviewed the records of five patients with hypothyroidism. The records showed that appropriate monitoring was in place for four patients and the practice had taken action to follow up a patient who had not attended for monitoring.
- We reviewed the records of five patients with asthma who have had two or more courses of rescue steroids in the last 12 months and found all had appropriate monitoring in place.
- We reviewed records for five patients with later stage chronic kidney disease and found that four patients had appropriate monitoring in place. We found one patient who was overdue monitoring. The practice had taken appropriate action for follow up.
- 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.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	45	50	90.0%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	54	61	88.5%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	54	61	88.5%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	55	61	90.2%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	59	67	88.1%	Below 90% minimum

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

Any additional evidence or comments

- The practice had not met the minimum 90% for three out of five childhood immunisation indicators. Practice staff told us that there was high levels of deprivation within the practice area which created challenges to their attempts to engage with parents or guardians to bring their children for immunisations. In addition a practice nurse had left and they had difficulties in recruiting another nurse. The position had now been filled and staff had continued to increase the uptake and follow up non-attenders where appropriate.
- There was a recall system in place to follow up children who were not brought for their immunisations. Practice staff also brought this to the attention of the practice's safeguarding lead and health visitor for further review and action.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	65.5%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	71.8%	55.7%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	59.6%	57.0%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	42.9%	50.3%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Any additional evidence or comments

- Practice performance for the uptake of cervical cancer screening was below the 80% England average target and the England comparison 70% uptake. The practice was aware of difficulties in their patient population and were working through their recall processes to engage with patients and encourage them to attend for screening. In addition to this, a new practice nurse had been employed and they had recently completed their cervical smears training.
- The practice uptake for breast cancer screening was higher than the local and England averages. The uptake for bowel cancer screening was higher than the local average but below the England average.

Monitoring care and treatment

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

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

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

<ul style="list-style-type: none">An audit was carried out to identify patients at risk of stomach ulcers and to check whether gastro-protection is also prescribed in order to minimise the risk to patients. The first audit identified 16 patients at risk of peptic ulceration due to not being provided with gastro-protection on their repeat prescriptions. All patients were contacted and appropriate action was taken. The audit was carried out six months later and identified there was no longer any patients identified to be at risk. The audit was repeated two years later and found that two patients were identified as needing an additional gastro protection medicine. The audit was discussed in a clinical meeting to ensure that staff took the appropriate action to achieve a reduced risk of ulcers in line with best practice. The audit will be repeated in six months time.
<ul style="list-style-type: none">An audit was carried out to identify patients on beta-blockers at risk of bronchospasm and prescribe alternative medications, where appropriate to minimise risk. The first cycle audit initially identified five patients, however three of these required a further review and appropriate action was taken. The audit was repeated ten months later and found one patient who required a review where action was taken to review their current medicine. The audit was completed again in September 2022 and found three patients were identified at risk and eligible to discuss the benefits of changing their medication to alternative options, where clinically appropriate. The practice found one patient had no worrying symptoms and wished to continue on their current medication and two patients were on eye drops which was started by secondary care and had no worsening of asthma. The practice will continue to review this audit and any learning to ensure any GP or non-medical prescriber is made aware of the need for cardio-selective or alternative medications for patients diagnosed with asthma.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Staff had access to and completed training identified as mandatory by the provider. • There was oversight of training which was monitored by the management team to ensure all staff were up to date with their training needs. • Clinical staff had opportunities to attend local networks and online events to help maintain skills and development. • Training records seen demonstrated that staff in extended roles had received appropriate role specific training for the work they performed. • We found that staff appraisals had been completed and development opportunities were discussed with staff members as part of this process. 	

Coordinating care and treatment

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

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

- The practice held regular integrated care meetings with community health care staff and community teams to discuss the care and support needs of all patients.

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Patients were able to access a range of service at the practice. For example, NHS health checks, vaccinations, spirometry testing and had access to a health trainer who offers a weekly clinic to discuss weight management and diet advice for patients as relevant. • The practice held diabetes clinics every three months alongside secondary services for specialist reviews of patients with complex health needs. • Through the Primary Care Network (PCN), the practice were able to access additional support. For example a social prescriber, physician associate and mental health services. 	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Y
Explanation of any answers and additional evidence <ul style="list-style-type: none"> • Training records showed that all staff had completed training relating to the Mental Capacity Act and Deprivation of Liberty Safeguards. • We reviewed two patients with a DNACPR in place and found these were appropriate. • Staff we spoke with had an understanding of relevant legislations and guidance when obtaining consent and decision making and had access to policies and procedures to support them. 	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was mixed about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Staff understood the needs of the population and had received appropriate training in providing a chaperone service as well as promoting equality and diversity.	

Patient feedback	
Source	Feedback
NHS UK	Feedback from patients reported that their overall experience was good and staff took the time to deal with their query.
Google Reviews	The practice was rated 1.6 out of 5 stars based on eight reviews in the last 12 months. Some reviews reported concerns and delays in getting an appointment and the attitude of staff. However, there was a positive review about the patient experience of the service reporting that staff were courteous and efficient in carrying out their duties and commended for their excellence.

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	65.7%	78.9%	84.7%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	66.7%	76.9%	83.5%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	76.6%	89.4%	93.1%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	59.5%	62.2%	72.4%	No statistical variation

Any additional evidence or comments

- Results from the national GP patient survey was lower in response to caring than local and national averages. The practice had identified this and had developed an action plan to improve the patient experience.
- Areas in the action plan included educating patients around the appointment system, continuing to monitor telephone demand and make adjustments with the telephone provider where needed, reviewing language resources on offer to patients with language barriers, reviewing patient flow and carrying out an inpatient survey.

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

Any additional evidence

At the time of our inspection the practice was implementing an in-house survey form to capture feedback about the patient experience. They were continuing to liaise with practice staff on ways to

improve outcomes, whilst offering flexibility to their patient population and utilising interpreting services and staff members to assist patients who may face language barriers when attending appointments.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Resources were available such as language line and a hearing loop for patient support. Staff at the practice could speak a number of languages to support their patient population. Easy read pictorial material and education resources were available. There was carers information available in the practice to assist patients further. 	

Source	Feedback
Interviews with patients.	We spoke with a patient who told us that at times there were difficulties in getting through on the telephone, but overall they were happy with the service and patient experience and that they were always offered a same day appointment for their child.

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	85.4%	85.1%	89.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y

Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Interpreting service were available for patients if required. The practice also employed staff who were able to speak a number of languages to engage with the diverse population registered at the practice. 	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 86 patients who were carers which represented 1.5% of the practice list size.
How the practice supported carers (including young carers).	A health care assistant was the named care coordinator and information was available at the practice and on their website to signpost and support patients.
How the practice supported recently bereaved patients.	Bereavement information was available which offered a range of information to help families. Appointments were available with the GPs if needed. The practice manager acted as a point of contact for families who needed additional support. For example, death certification to enable prompt burial in line with families' wishes when bereavement occurred.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff recognised the importance of and took measures to ensure people's dignity and respect when using the service. Staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. There was information at reception alerting patients to this. 	

Responsive

Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice was aware of the needs of its population and worked with other practices in their primary care network to offer flexibility and develop services for the local population. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8:00am - 6:30pm
Tuesday	8:00am - 6:30pm
Wednesday	8:00am - 6:30pm
Thursday	8:00am - 6:30pm
Friday	8:00am - 6:30pm
Appointments available:	
Monday	9am until 11.30am and 3pm until 5.30pm
Tuesday	9am until 11.30am and 3pm until 5.30pm
Wednesday	9am until 11.30am and 3pm until 5.30pm
Thursday	9am until 11.30am and 3pm until 5.30pm
Friday	9am until 11.30am and 3pm until 5.30pm
	Extended access is available on Wednesday's 6.30pm until 8pm across sites within the primary care network.

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Additional nurse appointments were available until 8pm on a Wednesday for school age children so that they did not need to miss school.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice was open until 8pm on a Wednesday. Pre-bookable appointments were also available to all patients at additional locations within the primary care network area during the weekend.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. For example, the practice worked closely with substance misuse services and screened patients for alcohol misuse and referred patients where appropriate.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and refugees who were offered a comprehensive assessment of their physical and psychological needs and signposted to relevant services. The practice worked with migrant support services including organisations for victims of torture.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

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

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• During the COVID-19 pandemic, requests for a face to face appointments were triaged by a clinician.• At the time of our inspection, changes had been made and the practice was offering a range of appointment types to patients.• Reception staff followed a protocol and had received training on which conditions could be dealt with by each clinical professional.	

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	39.5%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	47.6%	46.1%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	51.0%	48.6%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	72.5%	64.8%	71.9%	No statistical variation

Source	Feedback
Google Reviews	There was negative feedback around the experience of getting through on the telephone to the practice. The practice staff were aware of the demands on the telephone system and had kept this under review. Adjustments were being made where needed.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	Eight
Number of complaints we examined.	Three
Number of complaints we examined that were satisfactorily handled in a timely way.	Three
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Zero

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> A complaints leaflet was available at the practice. The leaflet explained what action practice staff would take in response to complaints they received. The practice held a log of written and verbal complaints made to the practice. We looked at the records of three complaints reported within the last 12 months. Records showed that these complaints had been acknowledged and, after investigation, replied to in writing. Records showed that learning from complaints had been shared with relevant practice staff at practice meetings. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient complained about the delay in a referral by the practice to secondary services.	The matter was investigated by the practice the outcome of which found that the referral had been actioned the same day of being requested. The process of referral was explained to the patient and the practice agreed to increase the frequency of checking referrals to secondary service each day.
Patient recently registered from overseas and complained about referral to the hospital for further investigation following examination.	The process of referral and education around the NHS was explained to the patient. This was also discussed with staff to educate and signpost any patients registering at the practice from overseas with limited knowledge around referral processes.

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Leaders at all levels demonstrated experience, capacity and the capability needed to deliver quality and sustainable care.• The leadership team understood the challenges within their local population which included high levels of deprivation, health inequalities, a diverse population and barriers to accessing healthcare. They were committed to meeting the needs of the population and worked collaboratively with their Primary Care Network (PCN) and community services to achieve positive outcomes for their patient population.• Staff told us that the practice management were approachable and always took time to listen to all members of staff.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The vision and values for the practice were clearly set out. The provider told us how they aimed to provide the best quality care to their patients and practice staff were able to share with us the vision and values of the practice.• The practice had a realistic strategy and supporting business plans to achieve priorities which they kept under review. The business plan considered succession planning and joined up working with other practices to meet the patient population.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had clear policies and procedures accessible to all staff, for example, whistleblowing, safeguarding and health and safety. • The practice had whistleblowing and duty of candour policies in place and a nominated freedom to speak up guardian to support staff if they wanted to raise an issue. • We looked at a sample of training records and all staff had completed equality and diversity training. • All staff had received an annual appraisal within the last year. Staff were supported to meet the requirements of professional revalidation where necessary. • Practice meetings took place which provided an opportunity for staff to discuss issues. • All the staff we spoke with told us that they felt supported by management and leaders. • There was an open culture and clear learning within the practice. The management team and leaders encouraged the reporting of incidents to identify ways in which the practice could continually improve. 	

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

Source	Feedback
Staff feedback	It's a busy practice but everyone supports each other. There is a good relationship between staff. Leaders are professional and approachable.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had established governance arrangements in place including clinical meetings and regular communication with other providers such as palliative care nurses and health visitors.• Practice policies were accessible to all staff on the practice shared drive.• Staff were clear about their roles and responsibilities and felt supported by the management and clinical team.• The practice had policies in place to support staff within their roles. The policies contained clear information about the designated lead in areas such as infection, prevention and control and safeguarding. All staff were aware of the designated leads in these areas.• The practice had policies in place for sharing information with third parties, for example primary care network (PCN) staff.	

Managing risks, issues and performance

There were effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice undertook a range of risk assessments, for example, health and safety, fire, electrical safety and equipment calibration and infection control. These were carried out to ensure risks were identified, managed and improvements made to mitigate the level of risk.• Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness and busy periods.• There was a programme of clinical auditing in place to monitor quality and implement improvements.• There were systems in place to review the capacity, demand and workforce to ensure quality and sustainability was regularly assessed and monitored.	

- There was a business continuity plan in place and staff had been trained on how to respond to incidents such as medical emergencies.

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • During the pandemic the practice worked to meet the needs of its population by offering a telephone appointment. Other patients with language barriers or vulnerable were managed where appropriate in line with COVID-19. • During the easing of lockdown, the practice had opened its doors and face to face appointments were available for all patients without the need of a telephone consultation if required. 	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice could evidence they had systems and processes established to regularly review information and performance. This included the use of the Quality and Outcomes Framework (QOF), audits and action plans to improve clinical performance and outcomes for patients.	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice used NHS approved software when consulting with patients remotely.Staff had received training and had access to guidance when undertaking remote consultations.The practice had policies to support them on information governance and there was an IT lead in place.	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Staff told us their views were taken into consideration about the planning and delivery of services at the practice. • The practice had a patient participation group (PPG) however, they had not met since December 2021 but had plans to meet in October 2022. The practice staff told us that during this time they had continued to engage with members of the group. For example, gaining feedback regarding survey data and their in-house patient survey. 	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice made use of learning events, incidents and complaints to improve the service. • The practice had systems in place to monitor the quality of its services and to ensure patients were prioritised for reviews and monitoring. 	

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **UKHSA:** UK Health and Security Agency.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- **%** = per thousand.