

## Inspection Evidence Table

Delapre Medical Centre

(1-585175036)

**Inspection Date:** 27 June and 5 July 2023

Date of data download: 13/06/2023

## Overall rating: Inadequate

We last inspected Delapre Medical Centre on 2 March 2016. The practice was rated good overall and in all key questions. At this inspection, between 26 June and 5 July 2023, we identified significant concerns in the care and treatment of patients and the management of medicines. We found there were multiple gaps in the quality and efficacy of governance systems, particularly relating to management of risk, leadership and quality management. These concerns led to the key questions safe, effective and well- led being rated as inadequate, with the key question of responsive rated as good. Overall, the practice is rated inadequate.

## Safe

## Rating: Inadequate

At the last inspection on 2 March 2016, we rated the practice as good for providing safe services. At this inspection we rated the practice as inadequate for providing safe services. We identified several areas of concern including:

- Systems or processes were not established and operating effectively to assess, monitor and mitigate risks relating to the health, welfare and safety of service users. In particular, risks associated with staff undertaking chaperoning duties without a Disclosure and Barring Service (DBS) background check, had not been assessed. Nor had risks associated with the absence of appropriate health and safety checks for electrical, gas and water safety been assessed.
- There was no assurance on the immunity and vaccination status of staff employed to ensure risks to themselves and patients were minimised.
- There were gaps in infection prevention and control (IPC) systems. We found IPC standards were not always met.
- Safety procedures for fire were not adequate.
- Medicines management arrangements were insufficient.
- Systems for managing test results were ineffective.
- Staff were not always aware of action to take to report significant events.
- Safety alerts were not appropriately actioned.

### Safety systems and processes

**The practice had systems, practices and processes to keep people safe and safeguarded from abuse. However, some systems needed strengthening.**

<b>Safeguarding</b>	<b>Y/N/Partial</b>
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.	Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Evidence submitted by the practice demonstrated DBS checks were not routinely undertaken for all non-clinical staff, including those who undertook chaperoning duties. The practice advised there had been an informal agreement with staff that only those suitably trained in chaperoning would undertake this role. However, we found multiple gaps in training records for chaperone awareness for staff undertaking chaperoning duties. During the course of our inspection, the practice devised a formal risk assessment for all staff undertaking chaperoning duties without a DBS check and advised of their intention to complete a risk assessment for each staff member. The practice advised there was no risk of these staff being left alone with patients. An audit was undertaken in June 2023 to review the length of time taken to respond to requests for child protection reports. The report identified responses were impacted by GP leave. A repeat audit was scheduled for June 2024.</p>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>During the course of our inspection, we requested evidence to demonstrate the practice maintained oversight of the vaccination status of all staff in accordance with requirements. We saw the practice outsourced this to a local occupational health service. We found evidence in some staff files to demonstrate referrals had been undertaken. However, the practice did not maintain a log of staff vaccinations and was unable to provide assurance all staff had been reviewed by the occupational health service.</p>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
Health and safety risk assessments had been carried out and appropriate actions taken.	Partial

Date of last assessment: August to October 2022	Y
There was a fire procedure.	Y
Date of fire risk assessment: February 2013	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice undertook regular risk assessments relating to Health and Safety. However, we were advised portable appliance testing (PAT) had not been undertaken since October 2021. Five yearly fixed wire testing was overdue at both the main and branch sites, as was the annual boiler and gas safety check. Water safety testing to reduce the risk of Legionella was not being undertaken. The practice had not assessed any potential risks occurring as a result of these checks having not been done. The practice advised quotes had been requested from appropriate contractors to ensure the checks were completed as a matter of urgency following our inspection.</p> <p>Although a formal fire risk assessment had not been undertaken since February 2013, there were no identified risks that required actioning. The premises had remained largely unchanged and routine fire checks were undertaken. We saw evidence to demonstrate fire safety equipment was appropriately maintained and that fire alarm checks were undertaken weekly. We reviewed training records for fire safety and found 13 staff were overdue training. At the time of inspection there was only one trained fire marshal in situ. The practice could not demonstrate routine fire evacuation drills were undertaken.</p>	

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were not always met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out.	N
Date of last infection prevention and control audit:	31 August 2021
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was an infection prevention and control (IPC) policy, however, it was not followed. Evidence reviewed demonstrated not all staff had received training in IPC. Feedback received from some staff stated they did not feel competent in IPC standards and expectations relating to IPC standards within their role. The practice advised that due to a high turnover in staff there had been limited support for oversight of IPC. A clinical lead for IPC had been appointed in April 2023. There was no evidence to demonstrate regular IPC audits were completed and we found the practice was not meeting IPC standards in one of the clinical rooms we reviewed. For example, the clinical couch used for patients had multiple small tears, hand gel was not wall mounted and there were gaps in clinical flooring.</p> <p>The last IPC audit undertaken in August 2021 demonstrated many issues identified had been acted on. However, there were some structural and equipment changes that the practice had not acted upon due to</p>	

financial constraints. For example, the practice advised it intended to replace some sinks and flooring in clinical rooms when funds were available. Some measures had been implemented to support good IPC standards in the interim. For example, many chairs had been replaced and we were advised all carpeted areas received regular deep cleans from a contracted cleaning company.

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	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.	Partial
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed evidence of training records for staff and found multiple gaps, including in basic life support and sepsis awareness. Although there were several new members of staff due to undertake the training, we found evidence that established staff were also overdue refresher training. Feedback received from staff highlighted some staff were unsure where to find emergency equipment. During our inspection, the practice submitted an updated staff training matrix which demonstrated some staff overdue training for basic life support had completed their training. We were advised the remaining five staff would complete training as a matter of priority.</p> <p>The practice advised there had been a period of high staff turnover in the months preceding our inspection. This had resulted in staff working excessively to support the running of the practice and on occasion the closure of one site to ensure the service could operate safely. At the time of our inspection, whilst recruitment efforts were ongoing, the practice had secured multiple staff into vacant roles and advised the workforce was stabilising.</p>	

## Information to deliver safe care and treatment.

**Staff did not always have the information they needed to deliver safe care and treatment.**

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y

There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	N
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We found policies had not always been routinely reviewed. For example, the policy for the management of test results had not been reviewed since February 2013. On 5 July 2023, during our remote clinical searches, we found 371 pathology results which had not been reviewed. These results had been sent to the practice after 6.30pm on Friday 30 June to the time of review on Wednesday 5 July. Some of these results were marked as abnormal. The practice took immediate action to review all these results during our inspection.</p>	

### Appropriate and safe use of medicines

**The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation.**

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	1.00	0.93	0.91	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). (01/04/2022 to 31/03/2023) (NHSBSA)	7.1%	7.4%	7.8%	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 (01/10/2022 to 31/03/2023) (NHSBSA)	4.61	5.12	5.23	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	146.2‰	134.2‰	129.8‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.54	0.56	0.55	No statistical variation

Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	6.6‰	7.7‰	6.8‰	No statistical variation
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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.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	N
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.	N
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
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	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> <p>The clinical searches identified a total of 201 patients taking a medicine or group of medicines which may be used to treat epilepsy or nerve pain who appeared to be overdue appropriate monitoring. We sampled 5 patient records of these and found there were problems with the care for all 5 patients. On 7 July 2023, the practice submitted an action plan which stated urgent action would be taken to review the care of these patients by 31 July 2023.</p> <p>The clinical searches identified a total of 1,814 patients prescribed medicines to treat heart failure or high blood pressure. Of these, 453 appeared to be overdue appropriate monitoring. We sampled 5 of these records and</p>	



found there were problems with the care for all 5 patients. On 7 July 2023, the practice submitted an action plan which stated urgent action had been taken to reduce the risks to these patients as the practice had attempted to contact all these patients asking them to arrange appointments for care.

We undertook clinical searches of patients prescribed medicines that required frequent and specific monitoring, for example medicines used to relieve symptoms caused by active rheumatoid arthritis, such as inflammation, swelling, stiffness, and joint pain. Our searches identified 8 patients taking a specific medicine. Of these, 2 appeared to not be receiving appropriate monitoring. We discussed these patients with the practice and were assured there were no concerns with the care of these patients.

We reviewed the practice's process for ensuring safe handling and storage of blank prescriptions. We found blank prescription safety needed improving when the practice was closed. The practice took swift action to address concerns identified and implemented a system immediately to ensure all blank prescriptions were stored securely overnight. The practice submitted an updated policy for prescription management as further supporting evidence of action taken.

The practice offered supervision and support to non-medical prescribers. However, systems to formally document supervision had been newly developed prior to our inspection and had not been implemented. Staff we spoke with were positive about the support they received. The practice could not demonstrate it undertook regular prescribing audits to ensure prescribing was in line with current best practice guidelines.

The practice held appropriate emergency medicines and we saw evidence to demonstrate risk assessments had been taken in deciding which medicines would be stocked. Although there were systems in place to check medicines and equipment, we found two items were out of date. The practice removed the items immediately. We found there were alternative medicines within their expiry dates available for use.

#### Track record on safety and lessons learned and improvements made.

**The practice learned and made improvements when things went wrong, however, there were gaps in staff understanding on how to report incidents.**

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.	Partial
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.	Partial
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	12
Number of events that required action:	5
Explanation of any answers and additional evidence:	
The practice utilised a digital tool to report significant events. We saw evidence to demonstrate the practice had undertaken an annual review of significant events on 20 June 2023, to identify any themes and trends. We saw evidence that staff from across the organisation were able to report events and these were actioned	

accordingly. However, we found one event from January 2023 had not been actioned. The practice advised the staff member had not processed the record accordingly which had resulted in it not being actioned. Staff advised this event would be followed up as a matter of urgency and staff would be advised of the correct way to input significant events.

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

Event	Specific action taken
Breach of cold chain.	Following a breach in the cold chain all reception staff received training on how to maintain the cold chain and support vaccine safety.
Delay in change of prescribed medicines.	Systems reviewed and updated to include checks for prescribed medicines not requested by patients to reduce the risk of recurrence.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	N
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Whilst we saw evidence the practice had acted on some safety alerts; the provider was unable to demonstrate all relevant safety alerts had been responded to. We saw patients remained on combinations of medicines that increased their risk of complications in pregnancy without anything in their records to indicate this had been identified and the risk discussed with the patient or alternative treatments considered. Our searches identified 69 patients prescribed such medicines, of which we reviewed a sample of 5 records. Of those 5 records, 4 did not evidence the risk had been discussed with the patient or alternative treatments considered.</p>	



## Effective

## Rating: Requires Improvement

At the last inspection on 2 March 2016, we rated the practice as good for providing effective services. At this inspection we rated the practice as requires improvement for providing effective services. We identified several areas of concern including:

- We found gaps in systems to support some patients with long term conditions.
- We found evidence to demonstrate all patients taking medicines that required routine review were not receiving adequate care.
- Childhood vaccinations were below national targets.
- The practice had not met the national target for uptake of cervical cancer screening.
- There was no evidence of targeted quality improvement, for example through regular clinical audit.
- There was insufficient oversight of staff training, with evidence that multiple staff had not completed mandatory training (as designated by the practice).
- Not all staff received regular appraisals and there was no evidence of formal clinical supervision for non-medical prescribers.
- There was no embedded approach to managing and supporting patients with Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) to demonstrate the practice maintained effective oversight of DNACPR decisions.

*Quality and Outcome Framework (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 not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

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

The practice prioritised care for their most clinically vulnerable patients.	Y
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## Effective care for the practice population

### Findings

- 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.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

As part of our inspection, we undertook remote clinical searches of patients with long-term conditions and those experiencing poor mental health, including dementia. We found there were gaps in the practice's recall systems as the searches identified many patients who did not receive timely reviews of their health and medication. For example:

- We carried out a search to review the monitoring of patients with hypothyroidism, specifically patients with hypothyroidism who had not had a thyroid function test within the previous 18 months. Our search identified 122 patients. We reviewed records for 5 of these patients and found none of them had evidence to support that they had received an appropriate test within this period. On 7 July 2023, the practice submitted an action plan which stated urgent action had been taken to reduce the risks to these patients as the practice had attempted to contact all these patients asking them to arrange appointments for care.
- A search carried out during our inspection, to review the monitoring of patients diagnosed with diabetic retinopathy and poor diabetic control; a complication of diabetes caused by high blood sugar levels showed 102 patients who may not have received appropriate monitoring. We reviewed a sample of 5 patients and 4 out of 5 patients had not received appropriate reviews or follow up care if results of tests were abnormal. On 7 July 2023, the practice submitted an action plan which stated they would review these patients by 21 July 2023.
- A search to review the monitoring of patients with chronic kidney disease at stages 4 or 5, identified patients who were coded as having this diagnosis had not receive all required monitoring tests. However, we found these patients were not at risk. For example, patients who were also under the care of a renal specialist were being reviewed every six months.

- A further search reviewed the management of patients with asthma who had been prescribed 2 or more courses of rescue steroids within the last 12 months. Our search identified 122 patients who had been prescribed 2 or more course of rescue steroids. We undertook a detailed review of 5 patients' records, which showed 3 out of 5 patients had an asthma and medication review within the last 12 months and were appropriately assessed at the time of treatment and had been followed up. The remaining 2 patients did not appear to be receiving care in line with guidance.
- 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 had facilitated group clinics for patients with diabetes and uncontrolled hypertension. These clinics supported 2 groups of 10 patients and were facilitated by specialist staff, including a GP, nurses, social prescribers and health care assistants. Staff described a positive response from patients following these groups and it was anticipated they would be established regularly in the future.
- 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.

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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	206	222	92.8%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	196	220	89.1%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	195	220	88.6%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	195	220	88.6%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	258	284	90.8%	Met 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 was aware it had not met the minimum target of 90% uptake for childhood immunisations for children aged 2 years. We were advised of efforts to improve uptake which included calling patients' parents or guardians following failed appointments, opportunistic discussions with guardians when attending the surgery and the provision of appointments outside of normal school and work hours.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	60.7%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	69.4%	N/A	70.3%	N/A
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). (12/31/2022 to 12/31/2022) (UKHSA)	64.6%	N/A	80.0%	Below 70% uptake
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	60.6%	56.5%	54.9%	No statistical variation

Any additional evidence or comments
Practice staff we spoke with were aware the practice had not met the national target for 80% uptake of cervical cancer screening. They advised there was dedicated administrative support to follow up failed appointments and encourage patients to attend. In addition, staff undertook opportunistic discussions with patients who attended the practice to encourage them to attend. Patients with a learning disability were supported to ensure they had access to cancer screening, this included longer appointments and liaison with carers where appropriate.

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y

The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	N
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	N

#### Any additional evidence or comments

Practice staff advised clinical audit activity had been limited since the COVID-19 pandemic. We saw evidence to demonstrate there was historic evidence of regular audits but there was no recent evidence of repeat cycle audits in the last two years. The practice submitted an audit undertaken in June 2022 to review monitoring of patients with hypothyroidism to ensure these patients received appropriate care. However, despite the audit recommending implementation of systems to ensure patients were recalled to the practice for appropriate monitoring, our own clinical searches identified 122 patients who had not been reviewed accordingly.

Practice staff advised they did not routinely review unplanned admissions. However, vulnerable patients who had been recently discharged from hospital received a follow up contact from the practice.

#### Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	N
Staff had protected time for learning and development.	Partial
There was an induction programme for new staff.	Partial
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
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed the practice's training matrix and found multiple gaps in training for several members of staff. This included mandatory training gaps (as per the practice's own designation) in infection prevention and control (IPC), basic life support, anaphylaxis, the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS), information governance and data security, equality and diversity, fire safety and chaperone awareness (for designated staff).</p> <p>Although the practice had protected time for staff to undertake training, managers advised the impact of the COVID-19 pandemic and high staff turnover and sickness had impacted on the ability of staff to complete training. Feedback received from some staff also reflected this as they advised they were not provided with adequate time to undertake training. Some staff advised they did not feel they had been given effective</p>	

inductions into their roles. Other staff commented positively on training and support and opportunities for career progression.

Whilst clinical appraisals were undertaken regularly, we were informed appraisals for non- clinical staff had been negatively impacted with several members of staff overdue or yet to receive appraisals.

### Coordinating care and treatment

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

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

### 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:  Patients had access to a dedicated social prescriber who, although employed through the practice's primary care network (PCN), was employed solely to support patients at Delapre Medical Centre and its branch Whitefields Surgery.	

### Consent to care and treatment



The practice always obtained consent to care and treatment in line with legislation and guidance. However, we identified gaps in systems to review DNACPR decisions to ensure effective oversight was maintained.

	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 Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Partial
Explanation of any answers and additional evidence We reviewed 4 patient records where a DNACPR decision had been recorded. We found for 2 of these the DNACPR decision had been reviewed within the preceding 12 months. One patient had recently transferred to the care of the practice and had not yet been reviewed; a review had not been undertaken by the patient’s previous GP practice since November 2020. The fourth patient had a DNACPR decision recorded but there was no supporting information within the record to demonstrate this was accurate. In planning for our inspection, the practice advised they had identified improvements were needed to their systems to review DNACPR decisions and ensure they maintained effective oversight of DNACPR decisions. Following our inspection, the practice submitted an action plan which stated they would review these systems and make improvements by 31 July 2023.	

Responsive

Rating: Good

At the last inspection on 2 March 2016, we rated the practice as good for providing responsive services. At this inspection we rated the practice as good for providing responsive services. We found areas of good practice:

- The practice identified a high prevalence of patients with complex mental health needs and responded by recruiting two dedicated mental health nurses.
- In an effort to improve patient experience the practice had invested in an e-consultation tool to support patients in accessing appropriate care. Steps were taken to ensure all patients, including those who were digitally excluded were still able to access care.

**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.	Y
Explanation of any answers and additional evidence: Members of the leadership team advised patient access was a priority for the practice. The practice was aware of the increasing demands for services and had developed new ways of working in response to this. This included the use of e-consults for patients who preferred to access care remotely.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm

Friday	8am – 6.30pm
Appointments available:	
Monday	8.10am - 6pm
Tuesday	8.10am - 6pm
Wednesday	8.10am - 6pm
Thursday	8.10am - 6pm
Friday	8.10am - 6pm

#### 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.
- The practice identified a high prevalence of patients with complex mental health needs and responded by recruiting two dedicated mental health nurses. There was at least one mental health nurse available each day the practice was open to undertake reviews, offer appointments and further support patients as needed.
- In corroboration with the practice's Primary Care Network (PCN), the practice employed a dedicated social prescriber (for the support of patient's registered at Delapre Medical Centre and its branch site only). Staff reported patient uptake for the social prescribing service had been high.
- 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.
- All parents or guardians contacting the practice with concerns about a child were offered a same day appointment when necessary.
- Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available from 6.30pm to 9.30pm Monday to Friday and between 9am and 5pm on Saturdays.
- Patients could also access GPs online via an online app which was available between 6am and 10pm daily.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- 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.**

Y/N/Partial

Patients had timely access to appointments/treatment and action was taken to minimise 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 (including those who might be digitally excluded).	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
<p>Explanation of any answers and additional evidence:</p> <p>Senior staff advised the practice had experienced growth in demand for appointments and support from the service by the local population which was also growing due to new housing development. The impact of the COVID-19 pandemic, staff sickness and staff shortages due to turnover had severely impacted patient access and patient satisfaction, with telephone lines clogged daily. In an effort to improve patient experience, the practice had invested in an e-consultation tool to support patients in accessing appropriate care. All patients were required to register for the digital service. Once registered they were able to access support through a series of prompts which then provided an appropriate access to care pathway for patients. This included signposting patients to more appropriate services if needed. All patients requiring support from the practice was logged on the system and actioned by duty doctors to ensure patients received timely care. This enabled clinicians to engage in e-consultations, telephone appointments or face to face appointments depending on need and patient preference. In addition, patients were able to track where their request was on the system.</p> <p>Staff advised that although there had been some initial difficulties with the system and patients understanding how to access the system, they had seen an increase in patient satisfaction. Patients who were digitally excluded and those who were not confident to use the system were supported by staff to access care. For example, patients were able to attend or call the practice to book an appointment and staff were able to use the digital platform on their behalf to request care.</p> <p>Patients were able to book routine advance appointments in person or by calling the practice. The practice had not reintroduced online appointment booking. Managers advised the aim was to utilise the newly implemented digital platform instead to ensure patients were receiving the correct care and appointment time was utilised most efficiently.</p> <p>During our inspection, we reviewed the practice's appointment system and found there were same day emergency appointments available on the day. Pre-bookable appointments were available the same week.</p>	

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
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)	43.6%	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)	59.2%	55.4%	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)	58.7%	52.5%	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)	71.5%	72.2%	71.9%	No statistical variation

Source	Feedback
NHS.uk website (formerly NHS Choices)	There were 3 comments posted in the 12 months preceding our inspection. Of those 3, 2 were negative and 1 was positive. Negative comments referred to delays in receiving care and staff attitude. Positive feedback reported on the prompt support offered by clinicians and staff and reflected favourably on staff attitude.

### 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.	24
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2

Number of complaints referred to the Parliamentary and Health Service Ombudsman.	1
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	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient incorrectly directed to use digital platform.	The practice responded to patient in accordance with its complaint’s procedure. Further training was offered to staff to reduce the risk of recurrence.



# Well-led

# Rating: Inadequate

At the last inspection on 2 March 2016, we rated the practice as good for providing well-led services. At this inspection we rated the practice as inadequate for providing well-led services. We identified several areas of concern including:

- There was a lack of clear responsibilities, roles and systems of accountability to support good governance.
- There were gaps in policies and protocols which resulted in an inconsistent approach in the management of risks.
- There was ineffective governance and clinical oversight to provide an adequate and safe service for service users.
- There were insufficient systems and processes established and operating effectively to assess, monitor and mitigate risks relating to the health, welfare and safety of service users.
- Staff feedback on the visibility and support offered by senior management and GPs was mixed.

## Leadership capacity and capability

**Leaders could not demonstrate that they had the capacity and skills to deliver consistent high quality sustainable care.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence:  Leaders were not always aware of the risks, issues and challenges in the service. Following the announcement of our inspection, the leadership team had identified some areas for action and improvement. Whilst some of these had been implemented when our inspection commenced, others were still outstanding and had been assessed and recorded in a formal risk assessment.  In response to the inspection, leaders responded proactively to feedback provided to them through the course of the inspection, taking swift action where possible and updating their action plan to address further identified areas of improvement. The practice was forthcoming in sharing this extensive and detailed action plan with the inspection team on 7 July 2023. Although several issues had been addressed, those outstanding had dedicated timeframes for completion recorded within the action plan.  We received feedback from 33 members of staff. Verbal and written staff feedback about the leadership team was mixed. Many staff spoke positively about working at the practice, with supportive colleagues and team leaders. However, 11 staff reported senior management and GPs were not visible or supportive. A further 4 members of staff advised support was not consistent. There was no leadership development programme, although some staff had been promoted and reflected on career progression opportunities. There was limited evidence of succession planning although discussions with leaders demonstrated there were plans in place for proposed upcoming retirements.	

Leaders described a cohesive relationship between members of the practice and primary care network (PCN) which helped to deliver high quality sustainable care, with a view to improve patient care and access, and invested in new ways of providing primary care.

### Vision and strategy

**The practice had a vision, but it was not supported by a 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.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	N
<p>Explanation of any answers and additional evidence:</p> <p>The majority of feedback forms received from staff stated they were unfamiliar with the practice's vision and had not been consulted in developing it.</p> <p>Leaders advised they did not have a formal business development plan and the high turnover of staff had adversely impacted such activity. We saw from the action plan submitted by the practice that the proposed development of a business plan had been recorded.</p>	

### Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	N
Staff reported that they felt able to raise concerns without fear of retribution.	Partial
There was a strong emphasis on the safety and well-being of staff.	Partial
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Partial
<p>Explanation of any answers and additional evidence:</p>	

Not all staff received regular appraisals. We saw multiple gaps in staff training with some staff overdue training by several years which had not been actioned by managers to ensure compliance and competency.

Staff views were mixed about the culture between team leaders and colleagues. There were 15 staff who reflected negatively on relationships with senior managers and GPs. Some staff commented on stressful work environments due to short staffing and high demand for the service. Some staff reported they were unsure it would be welcomed if they raised concerns about safe patient care. Others stated they had raised concerns and been ignored. Not all staff were aware there was a Freedom to Speak Up Guardian to provide support and advice to staff who wanted to raise concerns. Practice leaders advised the existing Freedom to Speak Up Guardian had recently changed roles and they were in the process of appointing a new Freedom to Speak Up Guardian. Leaders advised staff had access to an employee assistance programme for additional support with their general wellbeing and mental health.

There were 16 staff who had not completed training in equality and diversity.

### Governance arrangements

**The overall governance arrangements were ineffective.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	N
<p>Explanation of any answers and additional evidence:</p> <p>We saw evidence to demonstrate the practice had many systems, protocols and policies in place. However, evidence we reviewed demonstrated many of these had not been reviewed for several years. We found adopted policies and protocols that were ineffective. There was an infection prevention and control (IPC) policy, however, it was not being followed. There was a prescription management policy which did not ensure prescriptions were kept secure overnight. The practice was prompt to respond and update their policy to ensure identified risks were removed. There was a test result policy that was operating ineffectively as we found 371 outstanding pathology results that had not been reviewed. Staff reflected on difficulties they had experienced in ensuring assigned staff reviewed results on time. The practice was prompt to respond to concerns identified and review all outstanding pathology results during our inspection.</p> <p>In addition, in planning for our inspection, the practice had identified several written protocols and policies that were not available for us to review. Whilst they were prompt to action some of these, others were recorded within their own action plan to be completed as quickly as possible following our inspection.</p>	

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	N
There was a quality improvement programme in place.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	N
<p>Explanation of any answers and additional evidence:</p> <p>There was limited evidence of internal quality audit and risk assessment. This included clinical audits and risk assessments to assess, monitor and improve the quality and safety of the services provided. For example, there was no evidence of oversight of immunity and vaccination status of staff. Evidence of mitigating actions taken to reduce identified risks in relation to electrical, gas and water safety, as well as for staff undertaking chaperoning duties without a Disclosure and Barring Services (DBS) check were not evident. There was no ongoing system to monitor risks associated with infection prevention and control (IPC). We found evidence that appropriate IPC standards were not always being met.</p> <p>There was no evidence of formal clinical supervision for non-medical prescribers. The practice could not demonstrate that regular prescribing audits or reviews of consultations to ensure that appropriate prescribing following current best practice guidelines were taking place. There was a written protocol for clinical supervision of non-medical prescribers, but this had not been implemented. Not all staff received regular appraisals.</p> <p>In addition, we found ineffective systems to support safe medicines management and reduce risks to patients, as patients were not always receiving timely medicines reviews where required. Service users with long term conditions were not routinely monitored and reviewed in accordance with requirements.</p> <p>Evidence of a systematic approach to the management of Medicines and Healthcare products Regulatory Agency (MHRA) patient safety updates was lacking. There was no policy to support how safety alerts were actioned. There was no record of actions taken in response to safety alerts. Our clinical searches identified patients who had not been notified of potential risks associated with medicines they were prescribed.</p> <p>On 7 July 2023, immediately following our inspection, the practice submitted a comprehensive action plan which detailed specific timeframes within which they would address concerns identified during the course of our inspection. We noted some urgent actions relating to patient safety and effective medicines management had already commenced.</p>	

### Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	N
Performance information was used to hold staff and management to account.	N
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice acted in response to complaints and significant events. However, we found one significant event that had not been actioned since January 2023 as staff had not processed it correctly. Nonetheless this had not been identified in a review of significant events undertaken by management.</p> <p>In planning for our inspection, the practice advised they had identified improvements were needed to their systems to review Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions and ensure they maintained effective oversight of DNACPR decisions. This was reflected in our own review of 2 patient records. Following our inspection, the practice submitted an action plan which stated they would review these systems and make improvements by 31 July 2023.</p>	

### 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
Staff are supported to work remotely where applicable.	Y

**Engagement with patients, the public, staff and external partners**

**The practice did not always involve the public, staff and external partners to sustain high quality and sustainable care.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	N
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:  Staff reported that they had not been involved in the strategic planning of the practice.	

Feedback from Patient Participation Group (PPG).

Feedback
We spoke with a member of the PPG who reflected positively on the practice's efforts to engage with patients. We were informed the practice was open and honest with the PPG and keen to gather feedback and act on any identified concerns. They advised the practice took a proactive approach to improving services and meeting patient's needs.

**Continuous improvement and innovation**

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	N
Learning was shared effectively and used to make improvements.	N
Explanation of any answers and additional evidence:  We found multiple gaps in governance processes and little evidence to demonstrate improvements made due to a systematic approach to continuous improvement and quality assurance. However, the practice took a proactive approach in responding to the concerns identified through our inspection. They were forthcoming in sharing areas of improvement they had identified in their own preparation for the inspection and provided a detailed plan of actions on how they intended to improve.	



**Notes: CQC GP Insight**

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

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

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

The following language is used for showing variation:

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

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

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

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

#### **Glossary of terms used in the data.**

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