

Inspection Evidence Table

Dudley Wood Surgery

(1-7315549388)

Inspection Date: 9 November 2023

Date of data download: 18/10/2023

Overall rating: Inadequate

At the last inspection we rated the provider Good overall. At this inspection the practice is rated as Inadequate overall because:

- The practice did not have effective systems and procedures to keep patients safe.
- 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.
- There was limited oversight, induction and supervision for newly appointed staff and dependant practitioners.
- Staff were not always responsive to meet patient needs and complaints were not used to drive improvement.
- Leaders did not have sufficient governance and clinical oversight to ensure high quality, sustainable care.

Context

Information published by Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the third lowest decile (3 of 10). The lower the decile, the more deprived the practice population is relative to others. According to the latest available data, the ethnic make-up of the practice area is 91% White, 4% Asian, 1% Black, 3% Mixed, and 1% Other.

Safe

Rating: Inadequate

At the last inspection we rated the practice as good for providing safe services. At this inspection we have rated safe as inadequate because:

- Practice safeguarding processes were not embedded.
- There were gaps in staff immunisation status and no risk assessments had been completed to identify potential risks to patients or staff.
- The practice could not demonstrate that individual care records were managed appropriately, and that staff had access to relevant information to ensure safe care and treatment.

- The practice did not have appropriate systems in place for the safe management of medicines. This included an ineffective system for the management of safety alerts, as actions had not been taken to ensure patients were informed of potential risks with certain medicines.
- Clinicians were working on-site without adequate oversight and supervision.
- Patients on high-risk medicines were not always being monitored or reviewed regularly.
- The practice had not ensured medicines were administered by staff with appropriate authorisation.

Safety systems and processes

The practice did not always have 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.	Partial
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Partial
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had systems in place to safeguard children and vulnerable adults from abuse. This included policies and procedures, which were accessible to all staff on the practice shared drive; however, on reviewing policies we found that they required updating and we could not be assured that safeguarding registers were being routinely updated and reviewed. • The practice had a designated safeguarding lead in place. All staff received safeguarding training and staff records showed that clinical and non-clinical staff had completed training which was appropriate to their role. All staff knew how to identify and report safeguarding concerns. • Clinical meetings were held every week. However, on reviewing a random sample of meeting minutes we found no evidence to demonstrate that safeguarding concerns were an agenda item and discussed with the clinical team to highlight any ongoing concerns. • Staff meetings were not held on a regular basis. There was no set date for meetings and no set agenda and so were unable to gain assurances that safeguarding concerns were shared with the wider practice team. • Alerts were put on the records of patients identified as being at risk from abuse; however, we were unable to establish that the practice were actively reviewing and updating safeguarding registers and removing patients from the list once appropriate. 	

- Multidisciplinary meetings were held as part of the primary care network, where safeguarding and vulnerable patients were discussed, however there was no specific safeguarding meetings held with the health visiting team to discuss safeguarding concerns.
- Records we examined showed that not all staff had a DBS check in place. (A DBS check is a way for employers to check a criminal record, to help decide whether a person is suitable to work for them. This includes deciding whether it is suitable for them to work with children or vulnerable adults). We found that new and existing staff had their DBS pending, however risk assessments had not been completed for any staff with the exception of the practice nurse to mitigate potential risks whilst the results of the DBS checks were awaited.

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.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • We reviewed 6 personnel files and found appropriate checks had been carried out such as references, proof of identity and satisfactory conduct in previous employment had been sought in line with relevant guidance. • We found for some staff there was information relating to immunisation status that was missing and there were no risk assessments in place for staff who had not received the Hepatitis B vaccine to demonstrate potential risks of infection had been considered for both staff and patients. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Partial
Date of last assessment:	December 2022
There was a fire procedure.	Y
Date of fire risk assessment:	October 2023
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice had a health and safety policy and risk assessment in place; however, it was unclear whether the actions identified in the assessment had been completed. For example, for slips, trips and falls, regular checks are required to be undertaken but there was no documented evidence action had been taken. • A premise and security risk assessment for the building had been undertaken in December 2022. Actions that had been identified and completed with the replacement of fire doors throughout the practice. • There was an appointed fire marshal and staff had undertaken fire safety training. The last fire drill had been completed in December 2022. 	

- An annual gas check had been completed and water and air checks, including checks for legionella had been completed in May 2023. Portable appliance testing, calibration and fridge servicing had been completed in October 2023.

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.	Y
Date of last infection prevention and control audit:	June 2023
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> <ul style="list-style-type: none"> • There was an infection control lead in place and the most recent audit had been carried out in June 2023 by the Integrated Care Board (ICB) with an overall score of 84%. • The infection control audit had identified a number of areas for improvement. These included the cleanliness of the building as dust and dirt was visible, the replacement of noticeboards to wipeable boards that are impervious to moisture, the deep cleaning or removal of carpets to the stairs of the building, to replace gaps to the floors of some clinical areas and the decluttering of clinical rooms. At the time of our inspection, some actions had been taken to address the potential risks identified for example, a new cleaning contractor, however other areas still required action. • Policies were in place for infection prevention and control and were accessible for all staff. All staff with the exception of 1, had completed training for IPC. • 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 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.	N
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.	Partial
There were enough staff to provide appointments and prevent staff from working excessive hours.	Partial

Explanation of any answers and additional evidence:

- We found that the practice had recruited 3 members of non-clinical staff since September 2023, however there was no evidence that an induction had been completed. Staff told us that they had completed mandatory training but had not received an induction. We found that new staff were working unsupervised and providing buddy cover in the absence of the GP and practice manager.
- Most staff had completed anaphylaxis and sepsis training and 1 staff member had completed first aid training. We were unable to evidence that staff were up to date with basic life support training.
- We were not assured that staff working at the practice were supported to manage patients who may be acutely unwell and/or deteriorating, as during our inspection and at times there was no GP on-site to support staff with clinical oversight in the event of a medical emergency.
- We saw that emergency medical equipment was held at the practice, however, we found that not all equipment was being routinely checked. For example, adult and paediatric resuscitator equipment expired in September 2023 and had not been replaced.

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.	Partial
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.	Partial
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We were not assured that the GP clinical lead had robust systems in place to ensure locum staff and non-medical prescribers were being adequately supervised. Although the practice could evidence a recent audit of physician associates records, we found no evidence of supervision and instances where clinicians were working on-site without GP cover. • Our review of patient records in relation to the clinical searches undertaken identified that care records were inconsistently documented. For example, for asthma care we found that 45% of the 5 records we sampled did not have any clinical assessment when a course of steroids was issued. • We could not be assured that referrals to specialist services were consistently carried out correctly and managed in a timely way. For example, we found evidence that a referral for a patient was completed incorrectly by a physician's associate which caused a 16 day delay. • The practice held multidisciplinary meetings with other agencies to share and discuss information relating to patient care and treatment, for example, those on the practice palliative care register. 	

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) (01/07/2022 to 30/06/2023) <small>(NHSBSA)</small>	1.21	0.92	0.91	Tending towards variation (negative)
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). (01/07/2022 to 30/06/2023) <small>(NHSBSA)</small>	4.7%	5.7%	7.8%	Tending towards variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2023 to 30/06/2023) <small>(NHSBSA)</small>	4.38	5.25	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) <small>(NHSBSA)</small>	181.3‰	143.0‰	129.5‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) <small>(NHSBSA)</small>	0.62	0.62	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) <small>(NHSBSA)</small>	7.7‰	9.0‰	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.	N
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N
There was a process for the safe handling of requests for repeat medicines and evidence of	Partial

structured medicines reviews for patients on repeat medicines.	
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Partial
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.	Partial
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Blank prescriptions were not stored safely. The cupboard where they were stored was observed to be unlocked all day. The door leading to this cupboard was not kept locked and did not have restricted access. • Patient Group Directions or PGDs (a written instruction for the administration of medicines to groups of patients not previously prescribed for) were in place however the GP had not dated and put his particulars on 5 PGDs that were in use. The PGD for the administration of Pneumococcal vaccine in use was not signed or dated by a GP. 2 PGDs were signed and dated by a GP with a date after the PGD had expired. • Clinical searches of patient records were carried out as part of our inspection. A medicine (methotrexate) to treat rheumatoid arthritis which requires regular blood monitoring due to the risk of side effects, was looked at. It was found that of 15 patients who were prescribed the medicine, potentially 3 showed as overdue monitoring. For 2 of these patients, it was unclear as to who should be doing the blood tests the GP or the hospital. We spoke with the GP regarding methotrexate searches who told us that the practice was supported by the primary care network for medicines management who had missed these searches in error. • A search was done for monitoring patients on a high-risk medicine, that is used to prevent strokes in patients with a fast heart rate. The medicines belong to a group abbreviated to DOACs. 19 of 53 patients on DOACs potentially showed as overdue renal blood test monitoring. 5 patient records reviewed were all overdue monitoring and no contact had been made recently to do the monitoring required. This placed patients at risk. 	

- A search was done for medicines usage which looked at patients over 70 on blood thinners (antiplatelets) or pain medicines (non-steroidal anti-inflammatories NSAIDS) that can upset the stomach who could be considered to have a medicine (PPI) prescribed to protect the stomach. The search showed potentially 52 (58%) out of 89 patients had no PPI prescribed. When 5 records were reviewed all the patients on antiplatelet medicines without PPI had no review to discuss whether to start a PPI. This placed patients at risk of medicine side effects that could be avoided.
- A search on missed diagnoses of diabetes showed that 2 patients had been reviewed and followed up.
- On the day of inspection, a Physician Associate (PA) was proposing medicines to patients with no GP present on site and sending these medicines to be signed by a locum GP in the afternoon who had no oversight of the patients or the competencies of the PA. This was unsafe as PAs are dependent practitioners needing the dedicated supervision of a doctor. Other occasions where the PA was working on site without GP cover were noted meaning this was not a one-off. This put patients at risk by not having a GP on site overseeing the PA.
- A primary care network pharmacist was working at the practice on a Thursday. A system for clinical supervision was not evidenced. There were no slots in the pharmacist's clinic for clinical supervision by the lead GP which would be needed as the pharmacist was shortly to start prescribing. On the day of inspection, the pharmacist also had a clinic with no GP oversight.
- The reception team were all new to their roles. There was no assurance they would be able to monitor repeat medicine requests. Training to help them process prescription requests had not happened to date but all staff were handling medicines ordering requests. When questioned, staff were unable to identify medicines that should go as a query to the GP such as high-risk medicines rather than straight to signing.
- Four Standard operating procedures (SOPs) relating to medicines were due for review in June 2023 however none had been reviewed so were not in date. There was no evidence that staff currently working on reception had signed and dated to show the SOPs had been read.
- There was a new GP practice prescribing policy 1 January 2023, however this had not been approved by anyone or dated. Again, there was no evidence that new reception staff had read this policy as no signatures and dates were present.
- We found that patients were able to make online appointments, however this was only available with a nurse or health care assistant. We spoke with staff about the system in place and were told they checked for online appointments, however, were unsure of the overall systems in place.
- We found that the medical oxygen and defibrillator were regularly checked, however we found that further equipment such as an adult and paediatric resuscitator had expired in April and September 2023 and had not been replaced.

Track record on safety and lessons learned and improvements made

The practice did not always learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
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.	N
Number of events recorded in last 12 months:	2
Number of events that required action:	2
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice had a significant events and incident policy in place; however, these were not being discussed in any practice meetings and there was no evidence of learning. We found a number of examples from our inspection of missed opportunities to raise a significant event. 	

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

Event	Specific action taken
The filing cabinet containing confidential information had been left unlocked and the room where this is held was left open.	The process for locking and unlocking the room was reviewed in line with security to ensure information held is kept confidential at all times.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	N
Staff understood how to deal with alerts.	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> There was no clear process for acting on safety alerts. Records of actions taken against alerts were not evidenced. A search to look at an MHRA alert to monitor patients' renal bloods on a combination of 2 medicines 6 monthly at least, showed 7 of 9 patients were overdue. Monitoring based on this MHRA alert was poor. Reception staff were not aware of medicine safety alerts and what was meant by them when questioned. 	

Effective

Rating: Inadequate

At the last inspection we rated effective as good. At this inspection the practice is rated as inadequate for providing effective services because:

- The management of patients with long term conditions needed improving to ensure patients received the appropriate care and reviews.
- Patients' needs were not always assessed and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidelines.

- There was limited clinical oversight and a lack of supervision.
- The uptake for childhood immunisations was below the World Health Organisation (WHO) targets.
- The uptake for cervical cancer screening was below local and national averages.
- Newly appointed staff were working with no induction and limited oversight.
- We found the coding and reviews of patients with DNACPR's needed actioning.

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.	Partial
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.	Partial
The practice prioritised care for their most clinically vulnerable patients.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>We found that some of the systems and processes to ensure the safe, care and treatment of patients needed strengthening. For example:</p> <ul style="list-style-type: none"> • We found that 52 out of 89 patients over the age of 70, were prescribed nonsteroidal anti-inflammatory drugs (NSAID) or antiplatelets with no proton pump inhibitors (PPI) in line with NICE guidance. PPI's reduce the risk of gastrointestinal bleeding caused by the medicines. We sampled 5 records and found that all were at risk of gastrointestinal bleed, as a PPI was not given with the nonsteroidal anti-inflammatory drug (NSAID) or antiplatelet agent. 	

- We found inconsistencies in the monitoring of patients in line with some MHRA safety alerts. For example, 1 out of 2 patients prescribed Mirabegron (a medicine to treat an overactive bladder) was not fully monitored.
- We found some delays in the monitoring and reviews of patients with long term conditions, mental health and learning disabilities. For example, the practice had only carried out 1 out of 14 learning disability review in the last 12 months. The practice told us that some clinicians had left the practice and they had struggled to recruit permanent clinicians, however they had employed an ad hoc locum nurse to support with reviews such as asthma monitoring.

Effective care for the practice population

Findings

- Those identified received an assessment of their 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.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- Patients with a learning disability were offered an annual health check, however we found that these reviews were lacking and only 1 review had been completed in 12 months.
- 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; however, the practice had not carried out any mental health reviews in the last 12 months due to staffing issues.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- On reviewing the clinical system, we identified 2 out of 17 patients with hypothyroidism who had potentially not had the appropriate monitoring in the past 18 months. We reviewed 2 of these patients' records and found they were overdue blood tests and had been sent reminders by the practice.
- On reviewing the clinical system, we identified 17 out of 175 patients with Asthma who had received 2 or more courses of rescue steroid in the last 12 months. We reviewed 5 of these patients records and found all 5 patients had received an asthma review, however there was a lack of clinical assessment noted in the clinical records when a course of steroids had been issued. At the time of our inspection the practice had carried out 50% of asthma reviews in the last 12 months.
- We reviewed patients with chronic kidney disease stage 4 and 5 and found that appropriate monitoring was in place.
- We reviewed patients with diabetic retinopathy whose last blood test was above 74mmol. We identified that potentially 18 out of 187 had not had the required monitoring. We reviewed 5 of these patients

records and found inconsistencies. Whilst 1 patient had been reviewed, another patient had been followed up by secondary services and 3 had been sent reminders for review that required follow up.

- The practice was not always able to demonstrate that all patients with long-term conditions such as diabetes, asthma or Chronic Obstructive Pulmonary Disease (COPD) were offered an effective annual review to check their health and medicines needs were being met. At the time of our inspection the practice was trying to recruit additional clinicians to support with long term condition monitoring and reviews.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with COPD were offered rescue packs where appropriate.

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)	24	28	85.7%	Below 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)	24	28	85.7%	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)	24	28	85.7%	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)	26	28	92.9%	Met 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)	22	25	88.0%	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 was aware they were under target for childhood immunisations for 4 out of 5 indicators. The leadership team attributed some of the under achievement to the difficulty they had experienced in recruiting a second practice nurse.

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)	59.5%	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)	58.4%	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). (3/31/2023 to 3/31/2023) (UKHSA)	67.7%	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)	53.8%	48.3%	54.9%	No statistical variation

Any additional evidence or comments
<ul style="list-style-type: none"> Cervical screening was below the target of 80%. The practice attributed some of the difficulties in reaching this target due to difficulties in employing a further nurse.

Monitoring care and treatment

The practice had a 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
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <ul style="list-style-type: none"> The practice carried out a drop off urine samples audit which was initiated as the practice was struggling to test all samples each day due to clinical resources. There was also evidence that the testing of urine for a urinary tract infection (UTI) can be unreliable. The audit was carried out to determine the size of the problem and to look at an alternative intervention and reduce testing frequency unless there is a clinical need. In April 2023 the practice tested 100% of urine samples. After this date patients were asked to complete a urine infections questionnaire. A re-audit was carried out in August 2023 and found that only 1% of all patients who completed the questionnaire when providing a urine sample needed their urine sample testing before an intervention was made. 	

Effective staffing

The practice was not always 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.	Partial
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Partial
There was an induction programme for new staff.	N
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.	N
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
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">• At the time of our inspection, we did not feel assured that all staff had the skills, knowledge and support in carrying out their roles effectively. We found that a number of newly appointed and locum staff were working on-site with no managerial or clinical oversight.• The practice had a programme of learning, which was monitored by the management team each month. On reviewing a random sample of training, we found that staff were up to date with training requirements, which included newly appointed staff.• We found that newly appointed staff in post had not received an induction and were being tasked to carry out areas of their role with lack of understanding, knowledge and oversight. We spoke to the manager who told us that induction's had been delayed as the practice manager had been off work, however, were assured this would be actioned.• The practice had carried out an appraisal for a nurse, however most staff were newly appointed or were employed on a temporary basis.• We found instances where clinicians were working on-site without adequate supervision or oversight. Although the lead GP provided evidence of a recent clinical audit for 2 physician Associates (PA) consultations, we found that a physicians associate regularly carried out extended access with no GP on-site.	

Coordinating care and treatment

Staff did not always work 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.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Evidence was provided to demonstrate that the lead GP attended regular meetings within the primary care network. Attendance to these meeting was held with community teams and other practices to provide patients with co-ordinated care. Systems were in place to share information about patients electronically with other services. Clinical meetings were held every 3 months, however there was no evidence of regular staff meetings to ensure all staff were kept up to date with guidance and best practice. 	

Helping patients to live healthier lives

Staff were not always 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.	Partial
Patients had access to appropriate health assessments and checks.	Partial
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"> Due to difficulties in recruiting clinicians, we found some delays in carrying out annual reviews for patients. For example, we found backlogs in learning disability and mental health reviews. 	

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.	Partial
Explanation of any answers and additional evidence	

- All staff had completed training on mental capacity and understood legislation when considering consent and decision making.
- Our clinical review where a DNACPR decision had been recorded identified that further work was needed to ensure that DNACPR's had been reviewed and accurately reflected the most recent decision. For example, we found that when the practice received a DNACPR it had been coded onto the system, but was it was not clear whether this had been reviewed with the patient and by which clinician.

Responsive

Rating: Inadequate

At the last inspection we rated responsive as good. At this inspection the practice is rated as inadequate because:

- The practice did not always organise and deliver services to meet patients' needs.
- Patients could not always access appointments in a timely way.
- There had been a reduction in patient satisfaction in the length of time to make an appointment.
- Complaints were not used to drive continuous improvement.

Responding to and meeting people's needs Services did not always meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice provided online appointments through their website with a nurse and healthcare assistant, however at the time of our inspection, a healthcare assistant had not been employed for 6 months. In addition, there was no availability for online appointments with a GP. • We reviewed the appointment system and found that telephone and face to face appointments were only available with the GP during the mornings. The majority of afternoon appointments were with a physician associate and nurse. • The practice provided extended hour appointments on a Tuesday from 6.30pm to 8.30pm with a physicians associate. This was not available with a GP at the time of our inspection. Extended access appointments were available through the week at other locations as part of the Primary Care Network. 	

- Due to the lack of GP availability, we were not assured there was sufficient flexibility to meet patients needs due to potential delays in obtaining an appointment.

Practice Opening Times

Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 8.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	8.30am - 1pm and 1.30pm – 6.30pm
Tuesday	8.30am - 1pm and 1.30pm – 8.30pm
Wednesday	8.30am - 1pm and 1.30pm – 6.30pm
Thursday	8.30am - 1pm and 1.30pm – 6.30pm
Friday	8.30am - 1pm and 1.30pm – 6.30pm

- Appointment availability varied between GP, nurse and physicians associate.

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 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 with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child under 5, were offered a same day appointment when necessary.
- The practice was open until 8.30pm on a Tuesday. Pre-bookable appointments were also available to all patients at additional locations within the area.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and 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 not always 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.	Partial
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.	Partial
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> <ul style="list-style-type: none"> Results from the national patient survey reported ease of getting through to the practice by telephone; however, patients reported difficulties in the length of time taken to see a GP. For example, we found evidence of a delay in a patient referral to secondary services due to the length of time it took to see a GP for investigation. Evidence reviewed in the last 12 months demonstrated that patients survey results had seen an overall 20% decline in the satisfaction of appointment types and times that were offered to patients. Patients were able to access appointments face-to-face, by phone and through the practice website, however the facility for online appointments at the time of our inspection was only available for a nurse who worked 2 days per week. Patients were able to request repeat medication by requesting this on the practice website or through the NHS app. Appointments suitable for working patients were available at the practice on a Tuesday evening, however this was limited to a physicians associate. Extended access was available at other locations locally through the primary care network (PCN). Interpreter services were available for patients who did not have English as their first language. 	

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 (01/01/2023 to 30/04/2023)	75.9%	N/A	49.6%	Significant variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall	57.9%	44.4%	54.4%	No statistical variation

experience of making an appointment (01/01/2023 to 30/04/2023)				
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	52.9%	46.5%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	58.2%	65.9%	72.0%	No statistical variation

Any additional evidence or comments

- The practice continued to gather feedback through their friends and family test. Evidence provided from May 2023 indicated that 78% of patients were extremely likely or likely to recommend the practice.

Source	Feedback
NHS.uk website (formerly NHS Choices)	There were 5 reviews in the last 12 months and 3 of those were in relation to access to the service. Feedback reported that appointments were prompt and patients were able to get a same day appointment, whilst another review reported delays in being seen by a GP.
Googe Reviews	The practice was rated 2.4 stars out of 5 and there were 16 reviews in the last 12 months. Whilst some patients reported staff were helpful and they were able to get an appointment, others reported difficulties with getting appointments, there were difficulties with booking online and the service was poor.

Listening and learning from concerns and complaints

Complaints were responded to but not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	7
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.	0

	Y/N/Partial
Information about how to complain was readily available.	Partial
There was evidence that complaints were used to drive continuous improvement.	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> We did not see evidence that complaints were discussed with all staff or used as a way of improving the quality of care. 	

- We found the noticeboard in reception contained out of date information regarding how to make a complaint. We found that the named complaints manager no longer worked at the practice.

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient complaint that a 2 week wait referral was delayed.	The practice reviewed their referral and found it had not been accepted on the IT system. This was actioned and investigated to ensure there was a failsafe for checking future referrals for patients.

Well-led

Rating: Inadequate

At the last inspection we rated well-led as good. At this inspection well-led is rated as inadequate because:

- The practice did not have fully embedded governance systems and had not proactively identified and managed risks.
- There was a lack of leadership and oversight from the provider to ensure services were delivered in a safe and effective way to patients.
- Oversight was not effective to ensure processes were embedded.
- The practice culture did not always effectively support high quality sustainable care.
- There was no evidence of systems and processes for learning, continuous improvement and innovation.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme, including a succession plan.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The leadership team were aware of the challenges to quality and sustainability; however, we found this needed strengthening as a number of staff had left the practice and they were struggling to recruit clinicians which was impacting on the sustainability of the service. 	

- We found staff working at the practice did not have the appropriate oversight and supervision to ensure they were carrying out their role effectively. For example: we found instances where clinicians were working with no GP on-site.
- Staff described the practice team as supportive, however we found at times the management was not always visible.
- At the time of our inspection there was no business development plan. The practice told us this was being developed to ensure succession was in place and achievable.

Vision and strategy

The practice had a clear 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.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had a mission statement in place “To deliver high quality and effective health care to all of our patients, tailored and responsive to the needs of the local population. We aim to treat our patients with dignity and respect”. • As most staff were newly appointed or employed on a temporary basis and were not aware of the practice vision. • The practice was unable to provide evidence of a credible strategy to deliver quality, sustainable care. The practice told us that this was being reviewed. 	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Partial
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Partial
There were systems to ensure compliance with the requirements of the duty of candour.	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had policies and procedures in place to ensure compliance with the duty of candour, however they needed to improve how they shared learning with complaints to seek improvement. • There was a whistleblowing policy in place and a named freedom to speak up guardian. • Most staff had completed mandatory training which included equality and diversity. • No meetings had taken place with the team and there was a limited induction to ensure staff were competent and felt supported to carry out their role. • At the time of our inspection, a number of staff had left the practice and been replaced by new members. We were told of difficulties with working relationships with some members of the team which at times had created a negative culture in the workplace. 	

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

Source	Feedback
Staff interviews	<ul style="list-style-type: none"> • I have been made to feel welcome. • I do not always see managers. • It is getting better. • I sometimes feel supported. • Feel more support is needed. • Some staff are not approachable.

Governance arrangements

The overall governance arrangements needed strengthening.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice was unable to demonstrate that there was clear oversight of governance arrangements to ensure risks to patients were considered, managed and mitigated appropriately. For example: Some safety alerts had not been acted on appropriately and learning from significant events and complaints had not been shared with staff to mitigate future risk. • We found the clinical lead had no processes in place to ensure the appropriate oversight and supervision of nonclinical staff working at the practice. There were inadequate arrangements in place to ensure cover was sought in the GP's absence to support clinicians when working on-site unsupervised. 	

- We found some of the systems in place needed strengthening. For example, we found safeguarding registers were not being accurately reviewed and maintained.
- We found that some policies required updating. For example, complaints information contained incorrect information and a prescribing policy and standard operating procedures in relation to medicines management required updating.

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.	Partial
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Partial
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The leadership team were unable to demonstrate they had effective assurance systems in place to ensure patients received the appropriate care and treatment. When carrying out clinical searches we found patients with long term conditions were not being monitored appropriately and there were delays in carrying out reviews. • During the inspection we identified a number of patients on high-risk medicines that required a review and up to date monitoring. These risks had not been effectively managed by the practice’s own quality assurance and governance systems. • We found the practice needed to strengthen the systems in place to manage and oversee staff working in the practice. For example, we found that some clinicians and newly appointed staff were working on-site without induction, supervision or oversight and were not trained in basic life support. In addition, DBS checks were pending and there were no risk assessments held for those staff new in post carrying out work with no management oversight. 	

Appropriate and accurate information

There was a demonstrated commitment to using data and information, however this needed strengthening to proactively 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.	Partial
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"> Data was used to monitor and improve performance however some of the systems in place did not identify gaps in medicines management such as long term conditions and high risk medicine management. Our remote searches of the practice clinical system identified some concerns relating to the use of data and information to support decisions specific to patient care and treatment. 	

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
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. 	

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.	Partial
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"> • The practice had a patient participation group and had last met in July 2023. Prior to this the practice had hosted a prostate awareness event attended by the local mayor and local musician. • The practice engaged with other practices locally as part of the primary care network (PCN), however there was limited opportunities to involve all staff in the delivery of services due to limited meetings. 	

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.	Partial
Learning was shared effectively and used to make improvements.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We found no evidence to demonstrate that the outcomes from significant events or complaints, were shared with staff to promote learning and mitigate future risks. • We found that learning and improvement needed strengthening as there were limited opportunities for meetings and to review quality improvement activity to drive improvements. 	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of 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 those aged 25 to 49, and within 5.5 years for those 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.