

Inspection Evidence Table

Anchor Medical Practice

(1-508105811)

Inspection Date: 4 October 2023

Date of data download: 05/09/2023

Overall rating: Requires Improvement

We have rated the practice as requires improvement overall because we found that some of the overall systems and processes needed strengthening to minimise risk and keep patients safe. We found that recruitment, immunisation checks, mandatory training and health and safety risk assessments to support good governance were not always effective.

Safe

Rating: Requires Improvement

We have rated the practice as requires improvement for providing safe services as systems and processes needed strengthening to mitigate potential risks. This included recruitment procedures, checks of staff immunisations status/appropriate risk assessments.

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse, however some areas required strengthening to mitigate risk.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Partial
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> <ul style="list-style-type: none"> • The practice had safeguarding leads for both adults and children and policies in place to support staff in the event of a safeguarding concern. Staff we spoke with knew what to do if they had any concerns about a patient. • All staff had completed safeguarding training to the required level for their role, with the exception of 2 nurses who were trained to level 2, rather than level 3. The practice provided assurances that this oversight would be addressed promptly and was actioned the following day. • The practice held a safeguarding register, and the safeguarding lead reviewed safeguarding registers every 3 months to ensure records were accurate and up to date. Patient records we reviewed showed that they had been appropriately coded where safeguarding concerns had been identified. • Clinical system alerts were used to identify patients who were at risk of harm or abuse. The system also identified other close contacts so that staff were aware of other family members who could potentially be at risk. • We reviewed meeting minutes and found evidence that safeguarding concerns were discussed in practice and clinical meetings. • Records we examined showed that not all staff had a DBS check in place or in the absence of a DBS staff did not have a documented risk assessment to explain why a recent DBS was not required. At the time of our inspection, the practice had identified 8 members of clinical and non clinical staff who did not have a DBS check in place. We found that DBS checks had been applied for, however, risk assessments had not been completed to mitigate potential risks whilst the results of the DBS checks were awaited. We discussed this with the provider who put risk assessments in place immediately and provided assurances this would be reviewed annually. • Clinicians followed up children and young people who were not brought to their appointments both at the practice and for secondary care appointments. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
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> <ul style="list-style-type: none"> • We reviewed 5 personnel files and found there were gaps in appropriate checks such as references, DBS and proof of identity and no records to confirm that satisfactory conduct in previous employment had been sought in line with relevant guidance. • We found for some staff there was outstanding immunisation status 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. 	

- During our inspection, the provider had identified these gaps in their recruitment and immunisation processes and had started to review this. We found that the practice had gained assurances that staff working in the practice and employed by the Primary Care Network had been recruited appropriately.

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: ongoing	Y
There was a fire procedure.	Y
Date of fire risk assessment: 22 July 2022 (completed every 2 years)	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Staff had access to a health and safety policy, which had been reviewed in the last 12 months. • The practice was situated in a building with other NHS services. We were told that the property was managed by NHS property services who regularly carried out a schedule of routine maintenance for the building in line with health and safety, however the practice did not carry out their own health and safety audits or risk assessments. Following a discussion, the practice told us they would carry out an annual audit of their section of the building as outlined in their health and safety policy to ensure they had clear oversight. • Monthly water risk assessments including legionella were being carried out. Calibration checks for equipment and portable appliance testing was undertaken in December 2022 to ensure they were fit for purpose and were in good working order. • We found that 62% of staff had completed health and safety training. • A fire risk assessment had been carried out for the building in July 2022 and was reviewed every 2 years. There were fire procedures in place and weekly fire alarm testing carried out. The practice had 5 appointed fire marshals and training records showed fire safety training had been completed by 62% of staff. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: 31 January 2023	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	

- There was an infection control lead in place. We reviewed infection control training and found that 71% of staff had completed up to date infection prevention training relevant to their role.
- An infection control audit had been carried out in January 2023 with an overall score of 88%. Some areas had been actioned such as replacing ripped chairs and ensuring the minor surgery room has a domestic cleaning schedule. However, other areas required further approval from the building landlords. For example, relocating the minor surgery room and moving the reception area to another space within the building.
- We observed the general environment to be clean and tidy and the layout and facilities were spacious. Cleaning rotas were in place and there had been an annual cleaning audit carried out in September 2023 with an overall score of 94%.
- 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 adequate 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • A rota system was in place to manage staffing and room availability which was planned on a monthly basis. • The practice had an induction pack to support temporary staff and newly appointed staff working at the practice. • Systems were in place to ensure emergency medicines and equipment was checked on a regular basis. • Not all staff had undertaken basic life support and sepsis training but did explain the procedures to follow when encountering deteriorating or unwell patients. The practice told us that face to face CPR training was planned for all staff in November 2023. • Reception and administration staff who handled calls to the practice and arranged appointments with the clinical team were aware of potential red flag symptoms. Staff knew when to notify a GP or other clinicians with concerns. 	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. 1	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Our review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients. • There was a system in place to ensure all patient information including documents, laboratory test results and cytology reports were reviewed and actioned in a timely manner. • The practice had established systems for monitoring two week wait referrals to ensure patients were seen. • 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 had 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) (NHSBSA)	0.90	0.92	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). (01/07/2022 to 30/06/2023) (NHSBSA)	4.5%	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	4.95	5.25	5.24	No statistical variation

uncomplicated urinary tract infection (01/01/2023 to 30/06/2023) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	117.8‰	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) (NHSBSA)	0.35	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) (NHSBSA)	8.7‰	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.	Y
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. 1	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. 2	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	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.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y

Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> National prescribing data showed the practice prescribing was in line with local and national averages in all categories, with the exception of co-amoxiclav, cephalosporins and quinolones which evidenced the practice were tending toward positive variation in the appropriate and safe use of these medicines in comparison to local and national averages. There was a clinical lead in place who supported clinicians at the practice. We saw evidence that clinical meetings were held which included group supervision and peer to peer meetings. We found there was no formal audit activity of non-medical prescribers practice to ensure competency standards were maintained, however during our on-site visit, the practice confirmed audits would be undertaken in addition to the supervision and peer to peer meetings already in place and we were sent evidence to demonstrate this had been actioned immediately. There was a system and process in place for clinical reviews and our clinical searches showed that most patients had received appropriate medicine reviews. As part of our inspection, we reviewed a sample of patients on Disease-modifying antirheumatic drugs (DMARDS) and high-risk medicines that required regular monitoring due to the risk of side effects. We found that all patients identified had the required monitoring in place. Our searches identified 5 patients who were prescribed lithium, and all had the appropriate monitoring in place (lithium is a medicine used to treat mood disorders). We reviewed patients on potassium sparing diuretics (a medicine used to treat hypertension, cirrhosis, and congestive heart failure) and found potentially 14 patients were potentially overdue monitoring. We sampled 5 records and found appropriate monitoring was in place for all 5 patients. Our searches identified 13 asthmatic patients who were overs prescribed short acting beta antagonist (SABA) inhalers in the last 12 months. We reviewed 5 patients and found that appropriate monitoring was in place. There was clinical oversight for all requests to medicine changes and a clear process was in place to demonstrate what actions had been taken. We found that blank prescriptions were kept securely and there was a system in place to monitor usage. Emergency medicines, vaccines and medical equipment were appropriately stored and there were clear monitoring processes in place. There were appropriate arrangements in place for the management of vaccines and for maintaining the cold chain. We saw fridge temperatures were routinely monitored and vaccines reviewed at random were in date and stored appropriately. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y

There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	9
Number of events that required action:	9
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff we spoke with knew how to report incidents and significant events and were able to share examples of learning from them. We saw evidence in the documentation of significant events and the minutes of practice meetings that incidents were a standing agenda item and had been discussed with staff to support learning and improvement. 	

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

Event	Specific action taken
A referral for a patient was coded and filed and not sent to secondary services in error.	The practice realised their mistake and the referral was made urgently. The error was discussed with the relevant staff, discussed in a meeting, the process was reviewed, and the patient informed.
A letter was scanned into the wrong patients records and medicines was sent to the pharmacy for the incorrect patient.	The practice realised their mistake, this was discussed with staff involved and the letter and coding was amended and the correct patients medicines were sent to the pharmacy.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We found that the practice had a system in place to act on alerts which may affect patient safety. These were received by the practice manager and pharmacist and disseminated to the appropriate staff. We saw that safety alerts were discussed in clinical meetings. We saw examples of actions taken on recent alerts and the provider was able to demonstrate that all relevant safety alerts (including historic alerts) had been responded to. 	

Effective

Rating: Good

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
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.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Clinical staff told us that they accessed training and updates relevant to their roles to keep them up to date. They could access clinical guidance through the National Institute for Health and Care Excellence (NICE). Clinical issues were regularly discussed between members at clinical meetings and MDT meetings for example, reviews of safeguarding issues and recent deaths. Our clinical searches found patient's care and treatment was regularly reviewed and monitored for example, in relation to high risk medicines and long term conditions. There was evidence to demonstrate that a patient's current condition was discussed with them, medicine monitoring had taken place, a physical examination was carried out and the patient's wishes considered. Patient care plans had been shared with other organisations when appropriate and there was no evidence of potential harm to patients. 	

Effective care for the practice population

Findings

- Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check. We found that the practice had carried out 80% learning disability reviews in the last 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. The practice had carried out 66% of mental health reviews in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

Our clinical searches and record reviews indicated that most patients' with long term conditions were fully assessed and monitored in line with guidelines.

- The provider had implemented systems to monitor patients for potential missed diagnosis of diabetes and chronic kidney disease. However, we reviewed the records of 5 patients with a potential misdiagnosis of diabetes and found that 3 patients had not been coded appropriately. The practice took action to address this.
- Patients with asthma exacerbation requiring high dose steroid treatment for severe asthma episodes were always followed up in line with national guidance to ensure they received appropriate care.
- Patients with long term conditions were reviewed to ensure their treatment was optimised in line with national guidance.
- Patients with long term conditions such as diabetes, under active thyroid and chronic kidney disease were offered an annual review to ensure their treatment was optimised in line with national guidance. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice 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)	100	104	96.2%	Met 95% WHO based target
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)	76	80	95.0%	Met 95% WHO based target
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)	74	80	92.5%	Met 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)	75	80	93.8%	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)	94	102	92.2%	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>

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)	56.5%	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)	62.3%	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	74.9%	N/A	80.0%	Below 80% target

persons aged 50 to 64). (3/31/2023 to 3/31/2023) (UKHSA)				
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)	37.5%	48.3%	54.9%	No statistical variation

Any additional evidence or comments

- The practice was below the national target of 80% and practice staff were aware of this and had taken action to try to improve the uptake of cervical screening. The importance of cervical screening was discussed with patients at every opportunity. Written information was available to support and educate patients in making informed choices. There were systems in place for recalling patients to attend for their appointment.
- The practice nurse maintained records of cervical screening samples taken which they used to check that results had been received. Data was used as part of the recall process and annual audits carried out.

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
<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 provider had a programme of audits, these were mainly related to medicine optimisation. One of the audits we reviewed looked at reducing the carbon impact of inhalers used in the treatment of respiratory conditions. The audit had reviewed all asthma patients prescribed an inhaler and identified 52% of patients who met the criteria to switch to a more environmentally friendly inhaler. This audit remained under review every 6 months. • Other audits the practice had undertaken included: minor surgery, Novorapid to Trurapi Biosimilar Insulin Switch, lipids optimisation, antibiotic and DOAC audits. 	

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
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">• Training records we reviewed showed that not all staff had completed the provider's relevant mandatory training applicable to their role in a timely manner. For example, there were gaps in training such as basic life support, sepsis, fire safety, equality and diversity.• We saw evidence that clinical supervision and peer to peer meetings were held for clinicians working at the practice, however there was no routine audits being carried for non-medical prescribers employed. The practice took action to address this immediately during our inspection.• Appraisals were carried out annually and the provider used a structured appraisal format. We looked at a sample of completed appraisal forms and found that a formal process had taken place. At the time of our inspection staff were in the process of completing their annual appraisals.• We saw that the practice nurse took responsibility for their professional development and confirmed that they were supported to meet the requirements of professional revalidation. The practice also held educational meetings for nurses and health care assistants.	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Systems were in place to share information about patients electronically with other services.	

- The practice shared relevant information with out of hours services to support continuity of care.
- We saw evidence of regular staff meetings to ensure staff were kept up to date with guidance and best practice.

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice offered health checks to new patients registering with the practice and NHS health checks to patients aged 40 to 74 years, which enabled them to identify any health risks and provide appropriate support and guidance to patients. • Practice staff encouraged patients to attend cancer screening programmes and vaccination programmes. • Through the Primary Care Network (PCN), the practice staff were able to offer patients access to other services such as social prescribing, dietician, physio, and mental health nurse to support their overall health and wellbeing. 	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. 1	Y

Explanation of any answers and additional evidence
<ul style="list-style-type: none"> Staff we spoke with had an understanding of relevant legislations and guidance when obtaining consent and decision making and had access to policies and procedures to support them, however we did find that only 2 clinicians were up to date with training on mental capacity. Our clinical review of notes where a DNACPR decision had been recorded, identified where possible the patients views had been sought and respected and we saw that information had been shared with relevant agencies.

Caring

Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence:	

Patient feedback	
Source	Feedback
Google reviews	There were 19 reviews in the last 12 months. Feedback was mixed and reported staff were polite, considerate, gentle, compassionate, go above and beyond, very friendly and were good doctors, whilst others reported some staff were rude and there were long waits to answer calls.

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 stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 30/04/2023)	89.4%	78.8%	85.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare	88.9%	77.2%	83.8%	No statistical variation

professional was good or very good at treating them with care and concern (01/01/2023 to 30/04/2023)				
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2023 to 30/04/2023)	97.3%	89.5%	93.0%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	83.8%	61.1%	71.3%	No statistical variation

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

Any additional evidence

The practice had reviewed their patient survey results and kept this under review to benchmark their outcomes locally and nationally. They continued to collate feedback through family and friends feedback to improve the services.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There was information and support within the practice and on the website, sign posting to various services. The practice had access to a social prescriber employed within the primary care network (PCN) and patients were referred for support with their health and wellbeing. 	

Source	Feedback
Interviews with patients.	We spoke to 2 patients who told us that staff understand, listens and they feel involved in decisions about their care.

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 stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2023 to 30/04/2023)	88.0%	85.3%	90.3%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence:	

Carers	Narrative
Percentage and number of carers identified.	The practice had 87 patients registered as carers which represented 1% of the practice population.
How the practice supported carers (including young carers).	All carers were offered a flu and covid vaccination and signposted for additional support if required. For example, a social prescriber.
How the practice supported recently bereaved patients.	The practice maintained a register of patients who received end of life care and they were contacted by a GP when diagnosed with a terminal illness. The practice sent a letter detailing the support services available to them and patients were signposted to support services in the community.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

- Staff knew that if patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs. There was information at reception alerting patients to this.
- Confidentiality was covered as part of new staff induction and staff signed a confidentiality agreement as part of their employment.

Responsive

Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am - 8pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available: GP's	
Monday	9am - 12pm and 3pm – 6pm
Tuesday	9am -12pm, 2pm – 6pm and 6.30pm – 8pm
Wednesday	9am - 12pm and 4pm – 6pm

Thursday	9am - 12pm and 3pm – 6pm
Friday	9am - 12pm and 3pm – 6pm
Appointments available: Nurses	
Monday	8.30am – 6.30pm
Tuesday	8.30am – 5pm and 6.30pm – 8pm
Wednesday	8.30am – 6.30pm
Thursday	8.30am – 6.30pm
Friday	8.30am – 6.30pm

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

- Patients had a named GP who supported them in whatever setting they lived.
 - The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
 - In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
 - The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
 - Additional nurse appointments were available until 8pm on a Tuesday for school age children so that they did not need to miss school.
 - All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
 - The practice was open until 8pm on a Tuesday for appointments with a GP and nurse. Pre-bookable appointments were also available to all patients at additional locations within the area, as part of the primary care network.
 - 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 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> <ul style="list-style-type: none"> Patients were able to book appointments in person by calling the practice or through the website. There were telephone and face to-face appointments available. The practice regularly kept capacity and demand for appointments under review and analysed the appointments offered to patients. For example, during July 2023 the practice had offered 7,801 appointments. Further data reviewed demonstrated that the practice offered on average 1272 appointments per week, 39% of those appointments were with a GP, 32% were with a nurse and 29% were with another clinician. The practice had analysed their practice data from the national patient survey results and benchmarked this against practice's locally and nationally. Although the practice were above national averages in getting through on the telephone they had seen a decline in their outcomes since the pandemic. This included difficulties in the length of time it was taking for patients to get through on the telephone. To address this the practice had taken action and a new telephone system was due to be installed on 14 October 2023 with a go live date in November 2023. The practice took action to review their telephone system to increase the volume of calls coming into the practice and reduce the length of time calls were being answered, in addition to adding a queue system and call back facility for patients. 	

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)	65.1%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	73.3%	44.4%	54.4%	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 (01/01/2023 to 30/04/2023)	72.6%	46.5%	52.8%	Tending towards variation (positive)
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)	76.0%	65.9%	72.0%	No statistical variation

Source	Feedback
CQC feedback	We have not received any feedback about this service in the last 12 months.
Interviews with patients	We spoke with two patients on the day of the site visit, the feedback told us that they were able to get an appointment, however 1 patient told us about problems experienced when submitting information for a telephone review, however overall both patients were satisfied with access.
NHS.uk website (formerly NHS Choices)	There were 3 reviews posted on the website since November 2021 that related to access or appointments. 1 review was positive about appointments and access and 1 was negative. We saw the management team had responded to all comments and where feedback was negative, encouraged patients to make contact to discuss the concerns in more detail.

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.	17
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Some staff had completed complaints training. There was a complaints procedure and information on raising a complaint was available in the practice and on the website. Complaints were discussed with staff at practice meetings and relevant learning shared. Annual reviews of complaints provided the opportunity to identify themes and trends. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient complained that there was a delay in obtaining their prescription on the day it was requested.	The practice reviewed this further, apologised to the patient and explained the process for requesting repeat prescriptions to ensure they were clear on timeframes for prescription requests.
A patients arrived late for an appointment and was asked to rebook to be seen.	The practice apologised and sent a clear explanation outlining the reasons why they were unable to accommodate the patients late arrival on the day of the appointment.

Well-led

Rating: Requires Improvement

- We have rated well-led as requires improvement because there were system and processes to support good governance, however this needed strengthening to ensure risks were mitigated.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Leaders understood and acknowledged the challenges impacting on the delivery of the service including access. There was evidence of actions taken to address challenges such as the ongoing review of access and installing a new telephone system to improve access.• Staff were positive about leaders and said they were supportive.• The provider had effective processes to develop leadership capacity and skills and recruit a skilled workforce. The practice was a GP training practice which provided potential recruitment opportunities.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:	

- The vision and values for the practice were clearly set out. The practice's mission is to improve the health and wellbeing of everyone registered in our practice and to deliver outstanding integrated care by supporting our colleagues and nurturing an inclusive culture of kindness, respect and teamwork. We saw evidence of the mission statement on display in the reception area.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The management team operated an open-door policy and staff were encouraged to share ideas and raise any concerns. Staff told us that they felt able to raise any formal concerns. • The practice had a named freedom to speak up guardian and staff felt able to raise concerns. • The practice had whistleblowing and duty of candour policies. • Staff we spoke with were positive about the culture of the practice and found leaders supportive of their wellbeing. • We saw that whistleblowing and equality and diversity training were part of the mandatory training schedule, however not all staff were up to date with this training. For example, we found that that 71% of staff were up to date with Equality and Diversity. 	

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

Source	Feedback
Staff feedback	<ul style="list-style-type: none"> • Staff are always approachable and I feel supported. • It's a busy place to work but I feel supported. • Its an organised practice and good culture. • It's a face paced environment but feel supported.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Provider policies and procedures were available which were accessible to all staff. Discussions with staff showed they had an understanding and awareness of key policies such as safeguarding and whistleblowing. We looked at a sample of policies and saw they had been reviewed; however, we did find that some governance systems required further oversight such as recruitment, immunisations, and mandatory training.• There were meeting structures in place that were inclusive of all staff and ensured important information was shared throughout the practice team.• Minutes of meetings were available for those who were unable to attend the meetings.	

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance, however some areas needed strengthening.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• There was a business continuity plan in place to manage any major disruptions to the service provided. For example, loss of domestic services, loss of IT or flood. We found that the practice had arrangements in place with a neighbouring practice in the event of any disruption to ensure continuation of safe patient care.• Leaders had oversight of risks such as incidents and complaints and there were systems in place to identify and manage risk, however this needed to be strengthened further as the practice had failed to identify or risk assess several potential risks. For example, staff working in the practice who did not have a DBS check in place, the frequency in which DBS checks should be renewed, staff who had not	

received all of the required staff immunisations or, clinical staff who had not achieved immunity to hepatitis B.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Data was used to monitor and improve performance. Systems were in place to enable regular clinical searches in areas such as long term conditions and medicine management to take place. • Our remote searches of the practice clinical system identified no concerns relating to the use of data and information to support decisions specific to patient care and treatment. • The information used to monitor performance and the delivery of quality care was accurate and useful. • There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records, and data management systems. 	

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.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had a patient participation group with 7 members. At the time of our inspection, the practice was reviewing the group and considering merging this with another practice in the same building.• There were regular meetings for staff groups such as clinical and administrative staff which provided opportunities for staff feedback.• The practice worked with the local primary care network (PCN) and the Integrated Care Board (ICB) to deliver services for the local practice population which included providing an extended access service and medicine management.	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Learning and improvement was encouraged through staff appraisals, meetings and quality improvement activity.• The practice made use of internal and external reviews of incidents and patient safety alerts and learning was shared and used to drive improvements.• There were systems to support improvement and innovation work for example, the practice was an accredited practice for registrars and medical students.• The practice was a 'Research Ready' practice which meant the practice had met, the necessary requirements for research and could be actively involved with primary care research.	

Examples of continuous learning and improvement

- The practice had participated in research for Cardoso & DaRe2think.
- There were systems to support improvements demonstrated by ongoing quality improvement activity in areas of clinical practice such as high risk medicines.

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.