

Care Quality Commission

Inspection Evidence Table

Horsmans Place Partnership (1-565604154)

Inspection date: 20 October 2022

Date of data download: 28 September 2022

Overall rating: Inspected but not rated

This inspection, carried out on 20 October 2022, was to check progress against the requirements of the Warning Notices issued on 30 May 2022, for breaches of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe Care and Treatment and Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance.

The rating of Inadequate awarded to the practice following our full comprehensive inspection on 17 May 2022 remains unchanged. A further full inspection of the service will take place within six months of the original report being published and their rating revised if appropriate.

Safe

Rating: Inspected but not rated

At our previous inspection in May 2022, we rated the practice as Inadequate for providing safe services because:

- Safeguarding policies had not recently been reviewed and updated. The practice's computer system did not alert staff of all family and other household members of children that were on the risk register.
- Evidence that Disclosure and Barring Service (DBS) checks had been seen by the practice was not always available.
- Recruitment checks were not always carried out in accordance with regulations and practice policy.
- Staff vaccination was not always maintained in line with current Public Health England guidance.
- Risks to patients, staff and visitors were not always assessed, monitored or managed effectively.
- There was no record that reception staff had received training in the identification of 'red flag' signs or symptoms of sepsis in patients.
- The arrangements for managing medicines did not always keep patients safe.
- There was no formal clinical supervision or audit of the prescribing/consultations of non-medical prescribers.
- Learning from significant events was not always shared with relevant staff.
- Systems for managing safety alerts were not always effective.

At this inspection in October 2022, we did not rate the practice for providing safe services, because we only checked the progress made against the requirements of the Warning Notices issued on 30 May 2022.

We found:

- Safeguarding policies had been reviewed and updated. They contained information relevant to the practice.
- DBS checks had been completed and seen by the practice.
- Recruitment checks were carried out in accordance with regulations and practice policy.
- There had been improvements to the staff vaccination information held by the practice, however details for some staff members were not available.
- Risks to patients, staff and visitors had been assessed. However, it was unclear what actions had been taken to manage these risks.
- Reception staff had received training in the identification of 'red flag' signs or symptoms of sepsis in patients.
- The arrangements for managing medicines did not always keep patients safe.
- There was formal clinical supervision and audits of the prescribing of non-medical prescribers.
- Learning from significant events was shared with relevant staff at practice meetings.
- Systems for managing safety alerts were effective.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Explanation of any answers and additional evidence:	
<p>At our previous inspection on 17 May 2022, we found:</p> <p>The safeguarding adults policy, was dated as revised June 2014 with a review date of June 2015. As the policy had last been reviewed in 2014, the provider could not be assured external contact details were current. The safeguarding children policy was dated September 2012. The correct lead was stated on the policy but the deputy was on extended leave.</p> <p>Not all staff employed by the practice, including some clinical staff, were included within the practice's Disclosure and Barring Service (DBS) list (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Of the personnel files of five staff members reviewed, there were no DBS records available for three of these. There were no risk assessments for those omitted from the list of staff who had been subjected to DBS check.</p> <p>At this inspection in October 2022, we found:</p> <p>The practice's safeguarding adults policy and the safeguarding children policy had been reviewed in May 2022 and contained up to date details of safeguarding leads.</p> <p>All staff had received DBS checks appropriate to their role.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection on 17 May 2022, we found:</p> <p>Logs of staff measles, mumps and rubella (MMR) and Hepatitis B immunisations were incomplete and did not include records relating to all relevant staff members.</p> <p>The staff immunisation policy dated 12 May 2022, reflected current guidance in relation to staff immunisation requirements. However, when we reviewed personnel records of staff members, we identified a record of Hepatitis B status for two clinical staff members only. There were no other vaccination records available and/or variable immunisation records available relating to other staff members. Therefore, personnel records we reviewed and the practice's MMR and Hepatitis B log, did not reflect the practice policy in monitoring the immunisation status of staff.</p> <p>Personnel files also revealed that staff records were inconsistent/variable. For example, we found that no curriculum vitae (CV) or application form was held for two clinical members of staff. There were no references held for four clinical members of staff.</p> <p>At this inspection in October 2022 , we looked at the personnel records of five staff and found:</p> <ul style="list-style-type: none"> • There were immunisation records in line with current guidance and the practice's policy for three staff members. However, we could not find evidence of mumps immunisation for the other two staff members. The practice wrote to us after the inspection to show that they had assessed the risk of not having evidence of mumps immunisation for two staff members. One staff member was assessed as low risk as they did not work in a patient facing role. The other staff member was assessed as a medium/high risk as they did have patient contact, however we did not see evidence of any action taken by the provider to reduce this risk. • Recruitment checks had been completed for five members of staff, including CVs and references. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 8 June 2022	Partial
There was a fire procedure.	Yes
Date of fire risk assessment: 27 June 2022 Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection on 17 May 2022 we found:</p> <ul style="list-style-type: none"> • No health and safety notice in the building. 	

- There was a Legionella risk assessment that was not dated and had been completed by a staff member who had not been specifically trained to do so (legionella is a bacterium found in water supplies, which can cause severe respiratory illness). The risk assessment identified a requirement to monitor temperatures of the water from outlets once a month. However, only sporadic monitoring had taken place in 2017 and 2019 and no monitoring had been carried out since September 2019. Temperatures outside of the recommended range had been recorded at this time but had not been acted upon. The risk assessment stated the findings showed that the likelihood of legionella bacteria being present was low, so no further action was needed. This document had Horsmans Place as the title, but another practice was named above the monitoring section. No evidence that samples had been sent for analysis for Legionella was found. Therefore the provider could not be assured that the risks associated with Legionella were mitigated.
- The practice had a fire risk assessment (dated March 2021), but it had been completed by a staff member who had not been specifically trained to do so. There were no actions required as no risks were identified and no action plan or review date was recorded.
- Fire evacuation plans were seen on the walls in administration offices, in the waiting room and in the corridor upstairs. These were last reviewed in January 2019, therefore a review of these plans was required.
- There were three fire marshals named, and two had received fire marshal training, the third had received standard fire training. One of the marshals was currently on extended leave.

At our inspection on 20 October 2022 we found:

- There was a health and safety notice in the building.
- A legionella risk assessment had been completed on 8 June 2022 by an organisation specialising in the management of risks associated with legionella. The risk assessment had identified actions the provider needed to take. However, it was unclear whether these actions had been completed. We saw that water temperatures from outlets had been monitored each week from 22 July 2022 to 30 September 2022. We saw evidence that water samples had been sent for analysis. The results indicated that legionella was not present in these samples.
- A fire risk assessment had been completed by an external organisation on 27 June 2022. The risk assessment has identified actions that the provider needed to take. However it was unclear whether these actions had been completed.
- Fire evacuation plans were up to date and relevant to the practice.
- There were three fire marshals, we saw evidence that two had received fire marshal training. The third fire marshal remained on extended leave therefore, had been unable to complete the relevant training

Risks to patients

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

	Y/N/Partial
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes

Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
Explanation of any answers and additional evidence:	
<p>At our inspection on 17 May 2022, we reviewed the support and training to enable non-clinical staff within the practice to identify an unwell or deteriorating patient. We found staff applied a very low threshold for contacting medical staff for advice. However, there was no formal training for staff and no written guidance available to them which would support them in their assessment and decision making in identifying an unwell or deteriorating patient.</p> <p>At this inspection on 20 October 2022, we looked at the training records of five staff members and found that all had received training in the recognition and management of patients with potential sepsis appropriate to their role.</p>	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence:	
<p>At our inspection on 17 May 2022, we found that although there was a system for the management of safety alerts, it was not always effective. For example, a Medicines and Healthcare products Regulatory Agency (MHRA) alert from December 2014 advised that one medicine to reduce blood clotting and another used to reduce stomach acidity should not be prescribed together. Searches of the practice's clinical records system showed that five patients were found to be on this combination of medicines, despite having had recent medicines reviews.</p> <p>A search on another MHRA alert from 2014 related to two medicines prescribed to help manage depression. Searches showed that four patients over 65 had been prescribed doses higher than recommended.</p> <p>At this inspection in October 2022, we repeated the search for patients prescribed the combination medicines to reduce blood clotting and another to reduce stomach acidity that should not be prescribed together, we found one patient to be on this combination. The provider wrote to us after the inspection with evidence that this had been discussed with the patient and the medicine had been changed.</p>	

Appropriate and safe use of medicines

The practice's systems for the appropriate and safe use of medicines required improvement.

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial

Medicines management	Y/N/Partial
<p>There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.²</p>	<p>Partial</p>
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>For repeat prescribing, our clinical searches in May 2022 showed for patients on a 'four or more items on repeat' template that:</p> <ul style="list-style-type: none"> • The total number of patients on a 'four or more items on repeat' template was 2078. • Of those 2078 patients, the searches identified that the total number of patients with no medication review in the last 12 months was 1385; • The total number of patients with a medication review in the last 12 months was 693. • The total number of patients aged 65+ was 1101 and the total number of these patients with no medication review in the last 12 months was 695. This was contrary to good practice guidance. <p>Our clinical searches also identified a number of patients potentially at risk due to a lack of monitoring or diagnosis. For example, those prescribed high-risk medicines (Methotrexate, DMARDs (Disease modifying antirheumatic drugs), Azathioprine, Leflunomide, Lithium, Spironolactone; ACE inhibitors or Angiotensin 11 receptor blockers, Warfarin and New Oral Anti Coagulants (NOAC).</p> <p>The practice had a clinical supervision policy which was last reviewed in August 2018. The policy described the roles and responsibilities of various clinical staff in relation to the formal clinical supervision of colleagues. There were two non-medical prescribers working at the practice. One was employed by the PCN. Although both told us that they had access to informal help and advice at all times, we did not find any recorded evidence of formal supervision or audits of their prescribing.</p> <p>At this inspection in October 2022, we completed a series of searches on the practice's clinical records system. These searches were completed with the consent of the provider and to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance.</p> <p>We found:</p> <ul style="list-style-type: none"> • 39 patients were prescribed Methotrexate and two of these patients had not had the required monitoring tests. We raised this with the provider who told us that one patient had previously de-prescribed themselves from this medicine, but they were now restarting the medicine and had a plan in place for the patient to receive regular monitoring tests. The provider told us that one patient had the required monitoring tests at hospital and these results had now been added to the patients notes. • 96 patients who had been prescribed more than 10 prescriptions for benzodiazepines or Z drugs. (Benzodiazepines are medicines that may be used as a short-term treatment for severe anxiety, Z drugs are medicines that may be used as a short-term treatment of severe insomnia). The provider was aware that there were a high number of patients prescribed benzodiazepines or Z drugs and told us there were plans for a review in the next 12 months where, with support from clinical pharmacists, the practice would aim to reduce prescriptions of these medicines. We looked at the records of five patients and found that although side effects were discussed, risk of addiction was not always recorded within patient records for three of these patients. We shared these results with the provider who wrote to us with evidence that all patients had been contacted to discuss addiction risk and plans were made to gradually reduce prescriptions. 	

Medicines management**Y/N/Partial**

- Best practice guidance was followed for the monitoring of patients prescribed Lithium. Nine patients were identified by this search, this included one patient for whom this medicine had been discontinued. After sharing these results with the provider, the provider removed the medicine from this patients current prescription record.

We saw the practice had completed prescribing audits for non-medical prescribers and a clinical supervision policy been implemented, however this was not dated.

Effective

Rating: Inspected but not rated

At our previous inspection in May 2022, we rated the practice as requires improvement for effective because:

- Patients' needs were assessed, but care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- Patients with long-term conditions were not always receiving relevant reviews that included all elements necessary in line with current best practice guidance. Patient reviews were not always followed up in a timely manner where necessary.
- The practice carried out quality improvement activity, but there was not always evidence that they had implemented and followed up on the recommended changes.

At this inspection in October 2022, we did not rate the practice for providing effective services, due to checking the progress made against the requirements of the Warning Notices issued on 30 May 2022.

We found:

- The needs of some patients were assessed, but further improvements were needed to ensure care and treatment was delivered in line with current legislation, standards and evidence-based guidance.
- Some patients with long-term conditions received relevant reviews, but further improvements were needed to ensure inclusion of all necessary elements in line with current best practice guidance.

Effective needs assessment, care and treatment

Patients' needs were assessed, but 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.	Yes
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.	Yes
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes

Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
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The practice prioritised care for their most clinically vulnerable patients.	Yes
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Explanation of any answers and additional evidence:

At our inspection on 17 May 2022, our clinical searches identified a number of patients potentially at risk due to a lack of monitoring of their long-term condition. For example;

- Potential missed diagnosis of one patient of Chronic Kidney Disease (CKD) Stage 3-5, prescribed a thyroid hormone replacement medicine that had not undergone the appropriate monitoring in the previous 18 months,
- Patients with asthma who have had two or more courses of rescue steroids in the last 12 months and had not been reviewed and patients with diabetic retinopathy whose HbA1c was greater than 74 mmol/mol was 48.

At our inspection on 20 October 2022, we identified the following from our clinical searches:

- One patient as having a potential missed diagnosis of diabetes. This patient had been coded appropriately however, was overdue blood monitoring tests.
- 116 patients as having a potential missed diagnosis of CKD stage 3,4 or 5. The provider told us that they had increased the number of blood tests recently for medicine reviews which had led to the identification of these patients.
- 12 patients with asthma who had been prescribed 2 or more courses of rescue steroids. We reviewed four of these patients and found there was no evidence that these patients had been issued a steroid card. Two patients had not received a follow-up within a week of steroid use.
- Three patients with CKD 4 or 5 who had not had appropriate monitoring in the previous 18 months. We reviewed the records of these patients and found that all patients had received up-to-date monitoring at the hospital.
- 13 patients who had not had thyroid function test monitoring for 18 months. We reviewed five of these patients and shared our findings with the provider.
- 59 patients with diabetic retinopathy who's latest HbA1c was greater than 74mmol/l. We reviewed the records of five of these patients. One patient did not have diabetic retinopathy. Two patients were overdue for review, one patient had a medicine review but the content of this review was not clear, and one patient had out of range blood pressure result recorded.
- Three medicine reviews did not review all medicines for the patient. We looked at five medicine reviews and found that two reviews were clear and comprehensive.

We shared these results with the provider and after the inspection they wrote to us with evidence of:

- The patient with a potential missed diagnosis of diabetes had been sent reminders to attend for a blood test and to schedule an annual diabetes check.
- For each patient with a potential missed diagnosis of CKD; they would be coded appropriately. The provider then repeated the search and found there were now five patients shown as having a potential missed diagnosis. Again, the provider told us that these patients had since been coded appropriately. Two patients were reviewed in further detail. Both patients had received monitoring tests, however one patient who was receiving care from the hospital was not coded appropriately. The provider told us that this would be actioned on receiving the blood results from the hospital.
- A practice meeting that had been planned, where the issuing of steroid cards would be discussed, and in future follow ups would be scheduled for patients prescribed steroids.

- Coding for patients with CKD 4 and 5 was discussed at practice meetings to ensure that patients who received monitoring tests away from the practice were coded appropriately.
- For patients requiring thyroid function tests; one patient had received the appropriate monitoring tests and four patients had been sent reminders to attend for these.
- Patients with diabetic retinopathy who's latest HbA1c was greater than 74mmol/l; the two patients had been booked or contacted for review, one patients records had been updated to show details of the medicine review and one patient had now had an in range blood pressure measurement recorded.
- The Primary Care Network (PCN) employed another pharmacist as it was not possible to complete all medicine reviews with the current staffing levels. They also told us the two patients identified had received detailed medicine reviews and one patient had a review scheduled.

Well-led

Rating: Inspected but not rated

At our previous inspection in May 2022, we rated the practice as inadequate for providing well-led services because:

- There was compassionate leadership at all levels. However, leaders were not aware of all areas of the service where action was needed to ensure the quality, safety and performance of the service.
- Improvements were required to the processes and systems that supported good governance and management.
- The practice's processes for managing risks, issues and performance were not always effective.
- Processes to manage current and future performance were not sufficiently effective.
- Improvements to care and treatment were required for some types of patient reviews as well as subsequent follow-up activities.
- The policies and protocols for managing medicines did not always keep patients safe.

At this inspection we did not rate the practice for providing effective services, due to checking the progress made against the requirements of the Warning Notices issued on 30 May 2022.

We found:

- Leaders understood the areas of the service that required improvements to ensure the quality, safety and performance of the service.
- There were processes and systems that supported good governance and management.
- The practice's processes for managing risks, issues and performance were not always effective.
- Improvements to care and treatment were required for some types of patient reviews as well as subsequent follow-up activities.
- The policies and protocols for managing medicines did not always keep patients safe.

Leadership capacity and capability

There was compassionate leadership at all levels. Leaders had made some improvements to ensure the quality, safety and performance of the service.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes

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.	Yes
Explanation of any answers and additional evidence:	
<p>At our inspection on 17 May 2022, we saw there were policies available on the practice intranet, but many had not been updated for several years. For example, there was a looked after children GP practice checklist, but this had last been revised in 24 May 2013. The incident reporting policy and procedure was last reviewed in May 2017 and had not been updated since. The child safeguarding policy was dated September 2012 and the adult safeguarding policy had been revised in June 2014.</p> <p>We also found an infection prevention and control (IPC) policy, which had no issue date and stated it was version 1 and had been reviewed in April 2020. The policy lacked sufficient detail to provide guidance to staff and included reference to staff in lead roles who were no longer employed by the practice. A second IPC policy was identified by staff on the internal documents system. However, there was no date on the policy or version number although the expiry date was 1 June 2022. This was a more comprehensive policy and included for example, guidance on single use instruments, needlestick injury protocol, use of sharps bins, isolation of patients and notifiable diseases. However, it was unclear which of the two policies staff were expected to follow, as both were accessible on the internal practice system.</p> <p>At this inspection in October 2022, we looked at 14 practice policies and found that most of these had been reviewed within the last 12 months. One policy, the clinical supervision policy, was not dated.</p> <p>We found that both IPC policies identified at our previous inspection were still available on the practice's internal documents system. The provider showed us evidence of a draft IPC policy which was not yet available to staff for guidance. This policy did not contain information specific to the practice. For example, details were needed about clinical waste and the sterilisation and decontamination protocols. The provider told us they were being supported by Kent and Medway integrated care board (ICB) to complete this policy.</p>	

Managing risks, issues and performance

The practice did not always 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.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Explanation of any answers and additional evidence:	

At our inspection on 17 May 2022, we found there was a lack of awareness by leaders that improvements to quality, safety and performance were required in relation to the following:

- Safeguarding, in particular DBS checks.
- Staff vaccination/immunisation status.
- Risk management.
- Medicines management.
- Safety alerts management.
- Reviews and coding of patients with long-term conditions.
- Non medical clinical staff supervision.

At our inspection on 20 October 2022 we found that improvements had been made in relation to the following:

- Safeguarding, in particular DBS checks.
- Staff vaccination.
- Safety alerts management.
- Non-medical clinical staff supervision.

We found that although leaders had increased awareness of the following areas, further improvements were required in relation to:

- Risk management.
- Medicines management.
- Reviews and coding of patients with long-term conditions.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	
<p>At our inspection on 17 May 2022, we found there were no records of formal meetings or documented minutes of meetings within the last 12 months; in which patient complaints or reported incidents were discussed and there were no arrangements to review incidents or complaints as a team nor to record or disseminate learning or actions taken.</p> <p>At this inspection on 20 October 2022, we saw records of formal meetings and documented minutes of meetings from July 2022 to October 2022. This included practice meetings, nurses meetings and multidisciplinary team meetings. We saw that patient complaints and significant events were a standard agenda item for practice meetings, and that learning and actions taken were discussed.</p>	

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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