Care Quality Commission

Inspection Evidence Table

The Bermuda Practice Partnership (1-571172630)

Inspection date: 12-15 December 2020

Date of data download: 05 January 2021

Overall rating: Not rated

In order to seek assurances around potential risks to patients, we carried out a GP Focused Inspection Pilot (GPFIP) of The Bermuda Practice Partnership between 12 December 2020 and the 15 December 2020 to follow up on information of concern raised to CQC. We focussed our inspection on the following key lines of enquiry; Safe, Effective and Well-Led. We did not rate the practice or any key lines of enquiry during this focused inspection.

Safe Rating: Not rated

We undertook a focused inspection in response to concerns. We therefore did not rate the provision of safe services.

Safety systems and processes

The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	N
Partners and staff were trained to appropriate levels for their role.	N
There was active and appropriate engagement in local safeguarding processes.	Partial
There were systems to identify vulnerable patients on record.	Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial
We found that the practice did not have a robust safeguarding system to ensure patients were protected from abuse. For example, we found three examples where patients or their families had reported instances of domestic violence or other physical and emotional abuse. We found that in each	

Safeguarding	Y/N/Partial
instance the practice had failed to assess the risk of domestic abuse and/or violence and refer those patients to the local safeguarding authority. There were over 200 children registered at the practice who have been on a safeguarding register along with more than 20 looked after children. The practice did not remove children from the register when they were no longer deemed a safeguarding risk as they felt this may mean a future alert is missed. We were not assured that the practice were able to distinguish which patients were a current active risk from those with historical risk. We received a training matrix from the practice which showed gaps in training for safeguarding at all levels for clinical and non-clinical staff. We found that six out of 11 clinical staff had not received safeguarding adults training to a level appropriate for their role. Non-clinical staff did not receive any training in safeguarding adults. We found that three out of 23 non-clinical staff had not received safeguarding children training, and five out of the 11 clinicians were not trained to the required level for their role. We spoke to some members of staff, employed at the practice and found that clinical staff were not always aware of updated information around safeguarding. The clinical lead was also the safeguarding lead; they told us that regular meetings had taken place during the previous nine months throughout the pandemic which included the senior practice nurse lead, school nurses and health visitors. There was no policy at the practice to monitor failed attendances for children's appointments which meant that there were potential risks to children's safety. There was no assurance that children were protected from abuse, or that they were receiving the correct care such as necessary immunisation. We were told that the practice was not involved in formal meetings where adult safeguarding risks were discussed. Our patients' clinical records search found some incidents where clear safeguarding issues had not been investigated or discussed which meant that some patients at risk were not referred to social services and were at risk of harm. We found concerns relating to children prescribed anti-depressants further to inadequate assessments. For example, we reviewed four clinical records children that were being prescribed anti-depressants and found they were not being prescribed medicines in accordance with NICE guidance. They were also not being monitored or reviewed effectively, including consideration of safeguarding children.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
There was an effective induction system for temporary staff tailored to their role.	N
Comprehensive risk assessments were carried out for patients.	N
Risk management plans for patients were developed in line with national guidance.	N

Available workforce was inadequate to meet the needs of the patients. One of the partners had left the practice and the remaining GPs were experiencing challenges to provide clinical care and oversight of processes to keep people safe. At the time of the inspection, the practice included two GP partners supported by three part time salaried GPs, two of whom had been in post for less than three months. The nursing team was led by two part-time advanced nurse practitioners, supported by two part-time practice nurses and a part-time health care

Some administrative staff told us that staffing levels had improved during the last six months, but others felt that too many staff showed signs of stress because they felt unable to keep up with the workload. There had been several new staff appointed since the start of the pandemic; the circumstances and changes to usual practice meant that these staff had received insufficient induction to their roles. They understood that some face to face training was not available due to the Covid-19 pandemic and felt that under normal circumstances their roles would be more defined.

On reviewing a sample of patient records we found comprehensive risk assessments that followed national guidance were not always carried out for all patients. For example, in relation to the assessment of patients' symptoms and potential red flags and during medicine reviews. This meant opportunities were missed to ensure patients were receiving optimum care. For example, we discovered over 50 patients were prescribed a combination of medicines that were not recommended to be used together as such use may increase the risk of stroke of heart attacks. We sampled three records to review, two of which showed that the patients had recent events. The records did not demonstrate that this risk had been considered and steps taken to reduce the risk.

We found recall lists for chronic conditions were not effectively managed. For example, we reviewed the clinical records of patients with asthma who had been prescribed large quantities of reliever inhalers in the preceding 12 months. This might indicate poorly controlled asthma and national guidance requires that such patients are urgently reviewed. Half of the patients identified were overdue a review. We found that, where review had been undertaken, the overuse or over prescribing of these inhalers had not been identified or addressed

We also reviewed the records of 10 patients who were receiving reliever inhalers but had no diagnosis coded to their records of conditions that indicated this prescription. We found that five of those patients, where further investigation would be indicated to determine the cause of their breathing problems, and this had not taken place. One patient had attended for an asthma review which was documented but did not have the problem title 'asthma' coded to their records. The practice could therefore not be assured that all patients with an asthma diagnosis were recalled annually for review of their condition and prescribed medicines.

Information to deliver safe care and treatment

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

	Y/N/Partial
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Partial
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	N
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N

The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	N

A review of a sample of clinical records showed gaps in some clinical record keeping. In particular, we found seven clinical notes which did not contain adequate documentation of history, examination, diagnosis, follow up arrangements or detail of medicines reviews undertaken. For example, we found three patients receiving a medicine at a dose not recommended for their age group. This may have placed them at a higher risk of heart problems, leading to potentially fatal cardiac arrythmias. Practices had been alerted to this risk in 2014 via an Medicines and Healthcare Products Regulatory Agency (MHRA) safety update but we did not see evidence that this advice had been acted upon.

We found that the medical and prescribing history were not always apparent from the patient records and decision making in respect of these patients was not always clear or undertaken as requested. For example, a patient who had recently been discharged from hospital had not had a review of their medicines, blood pressure, or had blood monitoring checks done as requested in the discharge letter. In addition, the medicines that had been stopped by the hospital remained on the repeat prescribing screen, and could continue to be prescribed to the patient, placing them at risk of harm of renal impairment.

Patients were not always followed up to ensure investigations were completed and 2 week referrals made. One record we reviewed showed the clinician had documented a discussion in October 2020 regarding an urgent 2 week wait referral, but requested a further test prior to making the referral. . There was no evidence in the notes that this test had been done and no further action had been taken by the practice to chase this up or follow the patient up. Therefore, this patient potentially has a missed diagnosis of cancer.

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2019 to 30/09/2020) (NHS Business Service Authority - NHSBSA)	0.74	0.76	0.82	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). (01/10/2019 to 30/09/2020) (NHSBSA)	4.6%	8.1%	8.8%	Variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and	4.71	5.29	5.34	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2020 to 30/09/2020) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2020 to 30/09/2020) (NHSBSA)	112.0‰	87.7‰	124.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2019 to 30/09/2020) (NHSBSA)	0.62	0.71	0.68	No statistical variation

Medicines management	Y/N/Partial
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.	N
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	N

Our review of clinical records found a significant number of patients that had not received appropriate reviews or monitoring of their medicines. For example;

- We looked at 23 patient records of patients who were being prescribed medicines, including high risk medicines, that require monitoring. We found that 19 of those patients were not being monitored effectively or prescribed medicines safely. Medicines reviews were not being conducted in line with national guidance, for example NICE structured medicines reviews guidance. This means that patients are being prescribed medicines for which they were not being monitored, and checks were not being made to ensure the medicine is still safe, appropriate, effective, the correct dose being prescribed, not causing side effects, not interacting with other medicines and that prescription quantities are aligned.
- We found prescribing was not in line with national and local guidance; for example, we found a specific antidepressant prescribed to children contrary to NICE guidance which states antidepressants should only be prescribed to children following an assessment and diagnosis by a child and adolescent psychiatrist. There was no evidence documented in patient records that the clinician had considered the risks of prescribing this anti-depressant to children. We found examples of patients being prescribed medicines which were not in line with their recorded symptoms and condition. For example, a patient with asthma, was prescribed a medicine which was not recommended for patients diagnosed with asthma and this put them at risk of worsening their asthma.

The practice did not have templates for medicines reviews, though we were told that regular reviews were undertaken by the pharmacy team. Patient records did not demonstrate that appropriate prescribing and medicines reviews were taking place, this meant patients were put at risk of harm.

Medicines management	Y/N/Partial
The practice could not be assured that patients ongoing prescribing needs were appropriate to their condition or current needs.	

Track record on safety and lessons learned and improvements made

The practice did not have a system to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	N
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Partial
There was evidence of learning and dissemination of information.	Partial

Staff were able to tell us how they reported incidents and could give examples which were shared with the team at their weekly meeting. Staff had access to a local incident reporting system where incidents logs were maintained. It was not clear however, that there was a system in place to ensure that learning from incidents was acted upon and shared with all staff regularly.

The practice had been receiving external support from outside agencies for six months prior to our inspection. During this time one of the GP partners had taken leadership responsibility for the follow-up of significant events and was holding weekly meetings with clinical staff to discuss and learn from clinical events. We were given two recent examples of events that were discussed; one was related to a repeat prescription and the second was about the need for consistent blood test monitoring when on particular medicines.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	N
Staff understood how to deal with alerts.	N

The practice was unable to provide evidence that they received or acted upon safety alerts.

Our review of clinical records showed patients care and treatment had been compromised due to prescribing which was contrary to the patients' condition, or medicines combinations were prescribed contrary to safety alerts. We found that a lack of monitoring and action in relation to Medicines and Healthcare Products Regulatory Agency (MHRA).

Effective Rating: Not rated

We undertook a focused inspection in response to concerns. We therefore did not rate the provision of effective services.

Effective needs assessment, care and treatment

Patients' needs were not assessed, and care and treatment was not delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	N
Patients' treatment was regularly reviewed and updated.	N
There were appropriate referral pathways to make sure that patients' needs were addressed.	Partial
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	N

A review of clinical records showed clinicians did not always assess patients' needs and deliver care and treatment in line with current guidance. For example, patients prescribed a high-risk medicine were not routinely monitored in line with National Institute for Health and Care Excellence (NICE) guidance or specialist pharmacy service (SPS) guidance.

We found examples of inappropriate prescribing involving patients prescribed medicines which were contradictory to the safe management of their condition. For example, we identified a patient with heart problems prescribed a medicine at a dose that put them at increased risk of further such events. The information relating to this risk had been published in 2014, however, we saw that a medicines review in July 2020 did not mention that this risk had been identified or considered for the individual.

We found patient records were not regularly reviewed and updated and lacked detail which made it difficult to understand the care and treatment patients had received. For example, we found that medicines reviews were not completed regularly to ensure that medicines remained appropriate and safe for patient use.

The clinical records we reviewed contained many examples of inadequate coding which was of significant concern due to the serious impact on patient care. (Codes are placed on patients' clinical records systems to ensure they are recalled, monitored and reviewed effectively, in line with national guidance).

Annotations were often inadequate, with gaps in patient medical history and details of patients' symptoms making it difficult to understand the care and treatment required or the follow up monitoring necessary to improve the patient's health. We saw evidence that clinicians failed to instigate appropriate tests and investigations or carry out appropriate examination meaning patients were at risk of living with unidentified illness.

We identified patients who had potential missed diagnoses such as cancer, and chronic kidney disease.

We found evidence of actual or potential actual harm for three patients.

People with long-term conditions

Findings

Patients with long-term conditions were not always offered a structured annual review to check that their health, treatment and medicines needs were being met. We identified multiple concerns regarding poor care or no follow up of patients with long-term conditions.

Due to the lack of information recorded during GP consultations with patients, the practice were unable to evidence that clear and accurate information was shared with the patients or with other agencies looking after the patient's care, when deciding care delivery for patients with long-term conditions.

The practice did not undertake any audits of coding and it was evident that staff did not always code properly if at all. This meant the practice could not be assured that patients with long term conditions were appropriately identified and monitored. We found examples where repeat prescription lists were not updated following discharge from hospital with long term conditions.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	67.6%	74.3%	76.6%	No statistical variation
PCA* rate (number of PCAs).	1.5% (13)	16.5%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	79.6%	87.1%	89.4%	Tending towards variation (negative)
PCA rate (number of PCAs).	1.4% (5)	17.2%	12.7%	N/A
Long-term conditions	**Practice**	**CCG average**	**England average**	**England comparison**

The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	73.1%	76.9%	82.0%	Tending towards variation (negative)
PCA rate (number of PCAs).	2.5% (6.0)	6.0%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	56.7%	63.7%	66.9%	No statistical variation
PCA rate (number of PCAs).	10.0% (52.0)	18.5%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	60.8%	67.6%	72.4%	Tending towards variation (negative)
PCA rate (number of PCAs).	2.8% (50.0)	7.3%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	79.5%	88.8%	91.8%	Variation (negative)
PCA rate (number of PCAs).	2.4% (4)	4.0%	4.9%	N/A

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Partial
The learning and development needs of staff were assessed.	Partial
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Partial
There was an induction programme for new staff.	Partial
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N

Explanation of any answers and additional evidence:

Administrative staff with responsibility for coding care and treatment delivered to patients, had not been trained to do so. The Clinical Commission Group (CCG) had appointed an interim practice manager to oversee the non-clinical staff in supporting roles. Staff said appraisals had taken place and more delineation and clarity of roles had made some impact and improvement for staff and processes.

Following our inspection, the practice had organised training for staff to ensure that historical coding errors were addressed.

Clinical supervision and mentoring had also been arranged, following the inspection, to the GPs by another local practice.

Well-led Rating: Not rated

We undertook a focused inspection in response to concerns. We therefore did not rate the provision of well-led services.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Y

We found the practice did not have a stable or strong leadership and that the current partners had not understood the challenges to the practice or taken steps to address them, leaving patients at risk of an unsafe provision of care and treatment.

The practice were receiving support from the local medical committee (LMC) commissioned by the local clinical commissioning group (CCG). The senior partner had resigned a few weeks before our inspection; and an employed GP had joined the practice, forming a new partnership. The practice had not updated their registration with the Care Quality Commission following the formation of the new partnership.

The practice had employed a new practice manager in October 2020 and had strengthened the non-clinical management team by recruiting an operational manager the week before the inspection to support the day to day management of the practice.

Systems and processes were not in place to ensure the safe care of patients, this included; oversight of safeguarding registers, overall management of patients with long term conditions, lack of clinical oversight to ensure patients were receiving adequate care, treatment and medicines in line with NICE guidelines, accurate medical records, and actions in response to Mhra alerts.

Governance arrangements

Responsibilities and roles were unclear and the overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Partial

Explanation of any answers and additional evidence:

The practice was aware of some the shortfalls identified and had started to take steps to address these. However, other failings of governance systems had not been addressed due to the capacity of staffing. The oversight of clinical governance arrangements was not embedded and arrangements with supporting stakeholders was an ongoing process. We found ineffective governance systems which included but were not limited to;

- The delivery of safe care and treatment to patients, including appropriate recording of consultation, recall, monitor and reviewing of those patients.
- Safe prescribing systems including the implementation of safety alerts.
- Systems to ensure learning from significant events was shared with all relevant staff.
- Systems to ensure patients were safeguarded from abuse.
- Appropriate training for staff.

There were some meetings taking place for staff, but managers did not always involve staff appropriately. Some administrative staff were unsure of their roles and felt that they were 'picking up work randomly' A new operational manager was appointed two weeks before our inspection and was beginning to address this.
More recently, the practice manager had introduced weekly meetings which included all available staff, which the support staff we spoke with appreciated.

Staff were aware that they could find policies and protocols on the intranet; however, there was no evidence that policies were reviewed and updated on a regular basis. Some staff told us that this was partially addressed by the interim practice manager and the new operations manager had taken on the role more recently.

We found a lack of systems in place for the management of vulnerable patients and safety alerts.

Following our inspection, the provider submitted documents detailing actions taken since our inspection to address identified areas for improvement, however, actions were still in their infancy.

Managing risks, issues and performance

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

	Y/N/Partial

There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	Partial
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	N

The practice was unable to demonstrate they had effective processes to manage current and future clinical performance. In particular, the performance of clinical staff could not be demonstrated through audit of their consultations, clinical supervision and prescribing decisions.

The practice was receiving ongoing support from the local CCG and from the local medical committee in order to improve clinical care and oversee processes.

The clinical lead told us that the practice had begun to perform some clinical audits, focussing on hypertension, asthma, unopposed oestrogens. With support from the CCG they were also reviewing processes, and procedures to ensure patients with diabetes were monitored according to clinical need, in line with national requirements.

Appropriate and accurate information

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

	Y/N/Partial
Performance information was used to hold staff and management to account.	N
Our inspection indicated that information was accurate, valid, reliable and timely.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
Staff whose responsibilities included making statutory notifications understood what this entails.	Partial

We found that oversight of clinical governance did not routinely ensure that staff had access to information which was accurate and valid.

The clinical records we reviewed demonstrated a poor grasp of the importance of clinical coding at the practice. Data produced by the practice was inaccurate due to a lack of appropriate coding and could therefore not be relied upon for decision making.

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
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Partial

The clinical and management staff were working with stakeholders such as the local CCG and the primary care network (PCN) and were in receipt of support from the LMC.

The practice liaised with the district nursing team, safeguarding team, and school nurses in relation to information about vulnerable and at-risk children.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.

- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease.
- **PHE**: Public Health England.
- **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.
- ***PCA**: Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see GMS QOF Framework).
- ‰ = per thousand.