# Care Quality Commission

## Inspection Evidence Table

## Kirby Road Surgery (1-539233144)

**Inspection date: 24 to 26 May 2021**

**Date of data download: 24 May 2021**

# Overall rating: Requires Improvement

At our previous inspection on 25 September 2019, we rated the practice as requires improvement overall because the practice did not always ensure that care and treatment was provided in a safe way to patients. Effective systems and processes to ensure good governance in accordance with the fundamental standards of care were not established.

At the inspection dated 24 to 26 May 2021, we found some improvements had been made. However, the practice still did not always ensure that care and treatment was provided in a safe way to patients.

The practice remains rated as requires improvement.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

# Safe Rating: Requires Improvement

At the September 2019 inspection, we rated the practice as requires improvement for providing safe services because,

- Identified actions from infection prevention and control (IPC) audits had not been completed.
- Emergency medicines were not easily accessible. Some staff did not know where to locate emergency medicines and equipment. Some recommended emergency medicines were not held in the practice and there was no risk assessment in place to mitigate this.
- A log had not been kept that demonstrated that fire drills had been completed. Fire alarm checks were only completed every two months.
- There were lapses in security in the premises. NHS smartcards were left in keyboards when staff were away from desks. The reception office was unlocked and easily accessible to patients.
- There were concerns with health and safety in the practice.
- The temperature of the fridges used to store vaccines was checked each day. The thermometers were integral to the fridges. A second independent thermometer was not used to cross-check the accuracy of the temperature and to monitor the temperature if the electricity supply to the vaccine fridge was interrupted.

At the May 2021 inspection, we found the practice had made improvements related to the concerns found at the previous inspection. However, we found,

- Nursing staff were not trained to the appropriate level for safeguarding children and young people.
- There was not a process for the ongoing checks of the registration status of clinical staff.
- The system in place for high-risk medicines monitoring was not effective. We found some patients were overdue a review.
- Actions from a safety alert had not been followed. We found patients were prescribed a combination of two medicines that was not recommended.

Therefore, the practice remains rated as requires improvement for providing safe services.

**Safety systems and processes**

## The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse. However, not all staff were trained to appropriate levels.

| 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. | Y |
| There were policies covering adult and child safeguarding which were accessible to all staff. | Y |
| Policies and procedures were monitored, reviewed and updated. | Y |
| Partners and staff were trained to appropriate levels for their role. | N |
| 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. | Y |
| Staff who acted as chaperones were trained for their role. | Y |
| 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 |
| Explanation of any answers and additional evidence:<br>The nursing staff working in the practice had been trained to level 2 for safeguarding children and young people. The intercollegiate guidance Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff published in January 2019, states practice nurses should be trained to level 3.<br>Immediately following the inspection, the practice informed us the nursing staff were enrolled to undertake the appropriate safeguarding training. | |

| Recruitment systems | Y/N/Partial |
|---|---|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Y |

| | |
|---|---|
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role. | Y |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | N |

Explanation of any answers and additional evidence:

The registration status for clinical staff was checked on recruitment. There was not a system in place to carry out ongoing checks each time clinical staff renewed their registration.

Immediately following the inspection, the practice informed us a process had been put in place to ensure the registration of clinical staff would be regularly monitored.

| Safety systems and records | Y/N/Partial |
|---|---|
| There was a record of portable appliance testing or visual inspection by a competent person.<br>Date of last inspection/test: May 2021 | Y |
| There was a record of equipment calibration.<br>Date of last calibration: August 2020 | Y |
| There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. | Y |
| There was a fire procedure. | Y |
| A fire risk assessment had been completed.<br>Date of completion: October 2019 | Y |
| Actions from fire risk assessment were identified and completed. | Y |

Explanation of any answers and additional evidence:

At the September 2019 inspection, we were informed that the practice had completed fire drills and had an evacuation of the premises due to the fire alarm activating. There was no log or record kept of these.

A fire risk assessment had been completed in 2015. There had been no changes to the building that would indicate a new risk assessment was needed. However, fire alarm checks that had been completed weekly until May 2019 were now only done every two months. We were informed this was because they took too long to do. A further fire risk assessment had not been completed to support this decision.

At the May 2021 inspection, we found a fire risk assessment was completed in October 2019. Emergency lighting had been installed to the rear exit of the building. Waste bins had been removed from the porch area to reduce fire risk. A logbook was in place to record all actions taken in relation to fire safety including emergency lighting checks and fire drills. A fire drill had been completed in May 2021. The practice had carried out a review of how successful the fire drill was and identified actions to improve safety in the event of a fire. For example, the assembly location was reviewed and a new place was identified further away from the building.

| Health and safety | Y/N/Partial |
|---|---|
| Premises/security risk assessment had been carried out.<br>Date of last assessment: May 2021 | Y |
| Health and safety risk assessments had been carried out and appropriate actions taken.<br>Date of last assessment: May 2021 | Y |

Explanation of any answers and additional evidence:

At the September 2019 inspection, there had been no security risk assessment completed for the premises. We noted that NHS smartcards were not kept on person by individuals. We witnessed staff left smartcards in their keyboards when away from their desks. The reception office was easily accessible to patients; the door was open all day we were inspecting and patients could have entered and taken a smartcard or accessed other information. We were informed that staff did not take their smartcards home, they were locked in a cupboard at night, so all staff had access to all cards. NHS smartcards enable healthcare staff to access clinical and personal information appropriate to their role.

At the May 2021 inspection, premises and security risk assessments had been completed. A lockable door had been fitted to the reception office and glass screens at the front of the desk. The reception area was secure and not accessible to patients or visitors. Staff had been issued with lanyards to keep their NHS smartcards securely with them at all times. All staff had completed information governance training.

At the September 2019 inspection, there had been no health and safety risk assessments completed. We were informed that visual checks of the building were completed once a week, these were not documented. We noted there was raised wood on the floor at internal doorways in the practice that had not been identified as a trip hazard. There was a mercury sphygmomanometer in one of the GPs rooms for taking blood pressure readings. There was a mercury spillage kit available, but staff were not aware of the actions to take in case of a mercury spillage. Mercury can pose a risk to staff and patients if not handled correctly.

At the May 2021 inspection, we found that health and safety risk assessments had been completed. The raised wood at internal doorways had been removed. The patient waiting area had been refurbished with new seating and wipeable flooring fitted. The mercury sphygmomanometer had been removed from the practice.

**Infection prevention and control**

## Appropriate standards of cleanliness and hygiene were met.

| | Y/N/Partial |
|---|---|
| There was an infection risk assessment and policy. | Y |
| Staff had received effective training on infection prevention and control. | Y |
| Infection prevention and control audits were carried out.<br>Date of last infection prevention and control audit: May 2021 | Y |
| The practice had acted on any issues identified in infection prevention and control audits. | Y |
| There was a system to notify Public Health England of suspected notifiable diseases. | Y |

| | |
|---|---|
| The arrangements for managing waste and clinical specimens kept people safe. | Y |

Explanation of any answers and additional evidence:

At the September 2019 inspection, infection prevention and control (IPC) audits had been completed every six months. However, some actions identified on every audit since 2017 had not been actioned and there was no action plan in place to complete what was required. The identified actions included replacing splashbacks at sinks and redecoration. On the inspection, we noted the work surfaces in the treatment room were cluttered allowing for the potential collection of dust and there were no foot operated pedal bins in the staff and patient toilets to ensure safe disposal of hand towels and waste without cross contamination.

At the May 2021 inspection, we found that actions had been taken to improve IPC measures. The practice was visibly clean and free from clutter. There had been ongoing redecoration and identified repairs carried out although there had been some delays to planned work during the COVID-19 pandemic. There were pedal bins available in the staff and patient toilets.

Staff informed us that throughout the COVID-19 pandemic they had sufficient supplies of appropriate personal protective equipment (PPE).

COVID-19 specific risk assessments had been carried out for all staff to identify any mitigating actions needed to keep individual staff safe.

At the start of the COVID-19 pandemic the practice carried out a risk assessment of the premises and put measures in place to keep people safe.

**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. | Y |
| Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients. | Y |

Explanation of any answers and additional evidence:

At the September 2019 inspection, some of the non-clinical staff we spoke with did not know where to locate the emergency medicines and they were not easily accessible in case of an emergency. They were kept in a locked cupboard in a locked room.

| |
|---|
| At the May 2021 inspection, the emergency medicines were accessible and staff were aware of their location. |

**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. | 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 |

**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) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA) | 0.85 | 0.69 | 0.70 | No statistical variation |
| The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2020 to 31/03/2021) (NHSBSA) | 7.3% | 10.8% | 10.2% | No statistical variation |
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets | 5.53 | 5.54 | 5.37 | No statistical variation |

| Indicator | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2020 to 31/03/2021) (NHSBSA) | | | | |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA) | 125.2‰ | 98.3‰ | 126.9‰ | No statistical variation |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA) | 1.19 | 0.79 | 0.66 | 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. | N/A |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. | 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 high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. | N |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Y |
| There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. | Y |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance. | N/A |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | Y |
| For remote or online prescribing there were effective protocols for verifying patient identity. | Y |

| Medicines management | Y/N/Partial |
|---|---|
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates. | Y |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Y |
| Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective. | Y |

Explanation of any answers and additional evidence:

At the September 2019 inspection, some recommended emergency medicines (dexamethasone oral solution, dexamethasone injection, midazolam buccal or opiates) were not held in the practice and there was no risk assessment in place to mitigate this.

The temperature of the fridges used to store vaccines was checked each day. The thermometers were integral to the fridges. A second independent thermometer was not used to cross-check the accuracy of the temperature and to monitor the temperature if the electricity supply to the vaccine fridge was interrupted. We found a data logger in one of the fridges. However, the staff we spoke with were unaware of its existence and the purpose of it. Information from the data logger was not downloaded or monitored. Data loggers are useful to gain more detailed information about the fridge temperature if there was a cold chain failure, for example, a power cut.

At the May 2021 inspection, we found that risk assessments had been completed for any recommended emergency medicines not held.

Data loggers were used to monitor the temperatures of the fridges used to store vaccinations and a record kept of the temperatures.

The system in place for high-risk medicines monitoring was not effective. We found some patients were overdue a review. For example,

- There were 16 patients prescribed an immunosuppressant medicine, eight of these had not had the required monitoring.
- There were 928 patients prescribed a medicine used to treat high blood pressure, 268 of these had not had the required monitoring.
- There were 151 patients prescribed an anticoagulant medicine used in preference to Warfarin, 48 of these had not had the required monitoring.

Immediately following the inspection, the practice provided assurance that an action plan was in place to monitor these patients. Additional appointments were made available for patients to attend the practice for blood tests and then plans were made for patients to have a review with a clinician. There was a new pharmacist working in the practice to support these actions.
The practice also shared information regarding the searches carried out of the clinical system with the local clinical commissioning group (CCG) medicines management team to disseminate to other local practices.

**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: | 7 |
| Number of events that required action: | 7 |

Explanation of any answers and additional evidence:

At the September 2019 inspection, learning from significant events was not shared widely with the practice staff.

At the May 2021 inspection, we saw that learning from significant events was shared in clinical and practice meetings.

Examples of significant events recorded and actions by the practice.

| Event | Specific action taken |
|---|---|
| A patient was issued with a prescription for a higher strength of medicine than they should have had. This was noted by the patient who alerted the practice. | An investigation was carried out and an error had been identified as the patient had previously been prescribed the higher strength.<br>The event was discussed at the practice meeting and it was agreed that checks should be made to ensure the correct strength prescribed. All staff were reminded to raise any queries with a GP. |
| A skin lesion was removed from a patient that was later found to be a basal cell carcinoma. These types of lesions should be reviewed by a specialist prior to removal. | The patient was referred to a specialist for a review of the excision. The event was discussed at a clinical meeting and all GPs were made aware that a careful assessment of lesions should be made prior to removal. |

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

Explanation of any answers and additional evidence:

We found that there was a log kept of safety alerts and actions taken. However, when we reviewed the clinical system, we found that the actions for one alert had not been followed.

For example, there were 29 patients prescribed a combination of a medicine used to treat those who have had a stroke to reduce their chances of having a further one, and a medicine used to reduce stomach acid. A safety alert issued in 2014 advised that these medicines should not be prescribed together as the effectiveness of the medicine used to reduce the chance of having a stroke was made less effective.

Immediately following the inspection, we were informed that all of these patients had been contacted and alternative medicines were prescribed.

Appropriate action had been taken for another alert for medicines prescribed to treat epilepsy. We found that female patients of childbearing age had a recommended annual risk acknowledgement to show that the risks in pregnancy when prescribed valproate had been discussed. Valproate is a medicine used in the treatment of epilepsy and has a risk of congenital malformations in infants if taken by the mother during pregnancy.

# Effective Rating: Requires Improvement

At the September 2019 inspection, we rated the practice as requires improvement for providing effective services because:

- Exception reporting was high in some areas of the Quality and Outcomes Framework (QOF) monitoring.
- The uptake for cervical screening was below the 80% target set by Public Health England.
- Some single-cycle audits had been undertaken by individual GPs. However, these were not shared with other clinicians and two-cycle audits had not been completed to demonstrate quality improvement. There was no other quality improvement activity demonstrated in the practice.
- Staff development was not supported by the use of appraisals.

At the May 2021 inspection, we found:

- The Personalised Care Adjustment (PCA) rate, which replaced exception reporting, was high in some areas of QOF and the practice were unable to provide an explanation for this.
- The percentage of patients diagnosed with chronic obstructive pulmonary disease (COPD) who had received a review was lower than local and national averages.
- The uptake for cervical screening remained below the 80% target.
- Some patients diagnosed with dementia did not have a care plan in place.
- The practice had increased their quality improvement activity with findings of the single-cycle audits undertaken discussed and shared at clinical meetings. Timescales were in place to complete second cycle audits.
- A programme of appraisals for staff was in place. All staff had been supported with an appraisal in the preceding 12 months.

We have rated the practice as requires improvement for the population groups Long-term conditions, Working age people (including those recently retired and students) and People experiencing poor mental health (including people with dementia). Therefore, the practice remains rated as requires improvement for providing effective services.

**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 |

## Older people — Population group rating: Good

**Findings**

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medicines reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication 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.
- Housebound patients were able to receive blood tests and vaccinations at home.

## People with long-term conditions — Population group rating: Requires Improvement

**Findings**

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- The Personalised Care Adjustment (PCA) rate was higher than average for patients diagnosed with asthma and chronic obstructive pulmonary disease (COPD) who have had a review.
- The percentage of patients diagnosed with COPD who had received a review was lower than local and national averages.
- 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 shared information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with asthma were offered an asthma management plan.

| 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 | 80.5% | 78.4% | 76.6% | No statistical variation |

| | | | | |
|---|---|---|---|---|
| RCP questions. (01/04/2019 to 31/03/2020) (QOF) | | | | |
| PCA* rate (number of PCAs). | 35.3% (263) | 15.7% | 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) | 64.6% | 87.8% | 89.4% | Significant Variation (negative) |
| PCA rate (number of PCAs). | 27.3% (54) | 17.4% | 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) | 85.1% | 78.9% | 82.0% | No statistical variation |
| PCA rate (number of PCAs). | 5.1% (10) | 6.7% | 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) | 68.4% | 65.4% | 66.9% | No statistical variation |
| PCA rate (number of PCAs). | 19.2% (75) | 17.2% | 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) | 72.5% | 68.3% | 72.4% | No statistical variation |
| PCA rate (number of PCAs). | 4.5% (51) | 8.6% | 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) | 98.7% | 93.8% | 91.8% | Variation (positive) |
| PCA rate (number of PCAs). | 3.9% (6) | 3.8% | 4.9% | N/A |
| The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF) | 81.8% | 72.8% | 75.9% | No statistical variation |

| | | | | |
|---|---|---|---|---|
| PCA rate (number of PCAs). | 13.0% (51) | 14.0% | 10.4% | N/A |

| Any additional evidence or comments |
|---|
| The PCA rate was higher than local and national averages in some areas and particularly for the review of patients diagnosed with asthma and COPD. The data had been submitted by the practice in March 2020 and they were unable to provide an explanation for why the PCA rate was higher.<br>PCA replaced exception reporting in the Quality and Outcomes Framework (QOF). It enabled practices to differentiate between five different reasons for removing a patient from an indicator. |

## Families, children and young people Population group rating: Good

Findings

- The practice had met the minimum 90% for all of the five childhood immunisation uptake indicators. The practice had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of the five childhood immunisation uptake indicators.
- The practice had a recall system in place and contacted the parents or guardians of children due to have childhood immunisations. If a child was not brought to the practice for immunisations a designated staff member contacted the parents or guardians to make an alternative appointment.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

| 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) (01/04/2019 to 31/03/2020) (NHS England) | 103 | 106 | 97.2% | 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) (01/04/2019 to 31/03/2020) (NHS England) | 99 | 101 | 98.0% | Met 95% WHO based target |
| The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and | 99 | 101 | 98.0% | Met 95% WHO based target |

| | | | | |
|---|---|---|---|---|
| Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England) | | | | |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England) | 97 | 101 | 96.0% | Met 95% WHO based target |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England) | 105 | 113 | 92.9% | 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

## Working age people (including those recently retired and students)

## Population group rating: Requires Improvement

**Findings**

- The practice's uptake for cervical screening was below the 80% coverage target for the national screening programme set by Public Health England. There had been a gradual decline in the uptake for cervical screening. For example, at the September 2019 inspection there was a 75.5% uptake compared to 73.9% at this inspection.
- 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.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.

| Cancer Indicators | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| 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). (Snapshot date: 31/12/2020) (Public Health England) | 73.9% | N/A | 80% Target | Below 80% target |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE) | 68.7% | 70.2% | 70.1% | N/A |
| Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2019 to 31/03/2020) (PHE) | 66% | N/A | 63.8% | N/A |
| The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as | 83.9% | 90.5% | 92.7% | N/A |

| | | | | |
|---|---|---|---|---|
| occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF) | | | | |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE) | 59.6% | 57.2% | 54.2% | No statistical variation |

## People whose circumstances make them vulnerable

## Population group rating: Good

**Findings**

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- 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.
- Patients with caring responsibilities were identified and offered support.
- Patients were supported to shield during the COVID-19 pandemic with home visits provided including for blood tests and vaccinations.

## People experiencing poor mental health (including people with dementia)

## Population group rating: Requires Improvement

**Findings**

- Some patients diagnosed with dementia did not have a care plan in place. There were 57 patients coded as having dementia on the practice computer clinical system. Five patient records. were reviewed and of these two did not have a care plan in place. This meant clinicians may not have been aware of patients' specific needs or preferences and patients may not have received appropriate care and treatment.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.

| Mental Health Indicators | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| The percentage of patients with schizophrenia, bipolar affective disorder and | 90.5% | 80.1% | 85.4% | No statistical variation |

| | | | | |
|---|---|---|---|---|
| other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF) | | | | |
| PCA rate (number of PCAs). | 63.2% (36) | 27.2% | 16.6% | N/A |
| The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF) | 76.4% | 80.3% | 81.4% | No statistical variation |
| PCA rate (number of PCAs). | 5.3% (4) | 11.5% | 8.0% | N/A |

**Monitoring care and treatment**

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

| Indicator | Practice | CCG average | England average |
|---|---|---|---|
| Overall QOF score (out of maximum 559) | 547.8 | Not Available | 533.9 |
| Overall QOF score (as a percentage of maximum) | 98% | Not Available | 95.5% |
| Overall QOF PCA reporting (all domains) | 9.8% | Not Available | 5.9% |

| | 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. | Partial |
| The practice regularly reviewed unplanned admissions and readmissions and took appropriate action. | Y |

| Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years. |
|---|
| At the September 2019 inspection, single cycle clinical audits were undertaken by individual clinicians. However, these were not shared with other clinicians and two-cycle audits had not been completed to demonstrate quality improvement. There was no other quality improvement activity demonstrated in the practice.<br><br>At the May 2021 inspection, the practice had completed 11 single cycle audits. The audits had identified actions for improvements and timescales in place for when a second cycle should be carried out. There had been no completed second cycle audits undertaken. The findings of clinical audits were discussed and shared at clinical meetings. For example, the practice had undertaken an audit of patients who were prescribed Lithium, a medicine used to treat mood disorders, to see if they had received the appropriate |

| |
|---|
| monitoring to detect side effects. They identified that they needed to establish processes to ensure patients attended the practice for monitoring. It was agreed following discussion to implement the processes for all patients that were prescribed medicines that required additional monitoring.<br><br>The practice identified when an audit was required or when quality improvements were needed from a number of different areas including reported incidents, identified learning needs and patient safety alerts. |

**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. | Y |
| 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:<br><br>At the September 2019 inspection, we found only two members of staff had received an appraisal in the preceding two years.<br><br>At the May 2021 inspection, all staff had received an appraisal in the past year. Staff informed us they were supported in their appraisal to identify any areas for development. | |

**Coordinating care and treatment**

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

| Indicator | 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:<br>The practice held multidisciplinary meetings every three months to discuss patients with complex health needs and those on the palliative care register. We were informed these continued remotely online during the COVID-19 pandemic. | |

**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 |

**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. | Y |
| Explanation of any answers and additional evidence:<br>Records we reviewed showed personalised advanced care planning was in place to record patient's wishes.<br>The practice was following guidelines around Treatment Escalation Plans (TEPs), anticipatory care planning and Do Not Attempt CPR (DNACPR) orders. | |

# Well-led Rating: Requires Improvement

At the September 2019 inspection, we rated the practice as inadequate for providing well-led services because,

- There were flaws in the leadership and governance of the practice.
- Staff were not supported fully by the GP partners.
- Systems and processes in place were not adequately followed.
- A fire risk assessment had not been completed to support decisions made in relation to fire alarm checks.
- Essential risk assessments had not been completed in relation to security and, health and safety.
- There was a lack of staff meetings and formal communications with staff. Outcomes and learning from significant events and complaints were not shared with practice staff.

At the May 2021 inspection, we found:

- The provider had made improvements to the leadership of the practice. There was a new GP partnership formed. However, changes to governance structures particularly relating to policies and procedures were not fully embedded which led to concerns with the provision of safe services.
- The practice had not fully considered the needs of patients with a hearing impairment in relation to access during the COVID-19 pandemic.
- There had not been sufficient actions implemented in response to available data, to improve the practice performance from the previous inspection in September 2019.

Therefore, we rated the practice as requires improvement for providing well-led services.

**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:

At the September 2019 inspection, the GP partners did not fully engage with the inspection process. There was a lack of knowledge of some aspects of the practice management. For example, they were unaware of whether risk assessments had been completed, they did not have an overview of the training staff had undertaken and they were unaware of the location of emergency equipment and emergency medicines.

Staff informed us that they did not feel supported by the GP partners. We were informed that one of the GPs was due to retire. However, there was no succession plan in place.

At the May 2021 inspection, the practice had aligned with a neighbouring practice. They had developed a new GP partnership that consisted of GPs from both practices. There was practice management support from a GP managing partner.

Relevant risk assessments had been completed and there was a training matrix that provided oversight of all training staff had undertaken. All staff we spoke with were aware of the location of the emergency equipment and emergency medicines.

There were succession plans in place that included the change to the partnership.

The practice responded promptly to concerns found during the inspection with regards to providing safe services. They submitted evidence to provide assurance that actions had or would be taken to make the necessary improvements.

**Vision and strategy**

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

| | Y/N/Partial |
|---|---|
| The practice had a clear vision and set of values that prioritised quality and sustainability. | Y |
| There was a realistic strategy to achieve their priorities. | Y |
| 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:

Following the alignment with the neighbouring practice the provider had developed core values to guide staff when completing their work.

A strategy was in place to develop the practice that included diversifying the workforce to include different health care professionals to support the clinical team.

**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's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy. | Y |
| The practice had access to a Freedom to Speak Up Guardian. | Y |
| Staff had undertaken equality and diversity training. | Y |
| Explanation of any answers and additional evidence:<br>At the September 2019 inspection, staff we spoke with felt that not all of the GPs were supportive. Staff did not find all of the GPs approachable.<br>At the May 2021 inspection, staff we spoke with reported that there had been improvements made and they now felt supported by the GP partners.<br>The safety and well-being of staff had been considered during the COVID-19 pandemic. Individual risk assessments had been carried out and actions put in place to mitigate any risks identified. | |

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

| Source | Feedback |
|---|---|
| Staff | Staff we spoke with informed us they felt supported by the GP partners and practice management.<br>They stated they had received appraisals and were able to identify areas they wanted to develop. They were also offered additional training to support their development. |

**Governance arrangements**

## The responsibilities, roles and systems of accountability to support good governance and management were not always effective.

| | Y/N/Partial |
|---|---|
| There were governance structures and systems which were regularly reviewed. | Partial |
| Staff were clear about their roles and responsibilities. | Partial |

| | |
|---|---|
| There were appropriate governance arrangements with third parties. | Y |
| Explanation of any answers and additional evidence:<br>At the September 2019 inspection, the practice had policies and procedures in place. However, feedback from staff was that the GPs all had their own individual ways of working that they had to adapt to. There were no consistent systems for them to follow. Some of the systems in place were not adequately followed.<br><br>At the May 2021 inspection, the practice had carried out an audit of their policies to ensure they were current and relevant. Out of date policies were removed from the practice computer system so they were not accessed in error. Staff were aware of how to locate the policies. However, the policies were not fully embedded at the time of the inspection which led to concerns with the provision of safe and effective services. | |

**Managing risks, issues and performance**

## There were clear and effective processes for managing risks, issues and performance.

| | 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. | Y |
| 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:<br>At the September 2019 inspection, staff performance and development was not supported by appraisals. There were no full-cycle audits to demonstrate quality improvement. There was an absence of essential risk assessments. For example, security and, health and safety. Changes had been made to fire safety procedures in the practice that were not supported by a current fire risk assessment. Actions had not been completed following the infection control and prevention (IPC) audits.<br><br>At the May 2021 inspection, all staff had received an appraisal in the preceding 12 months to support their performance and development. The practice had increased their audit activity to identify areas of quality improvement and plans were in place to complete second cycle audits to demonstrate improvements had been made. Relevant risk assessments had been completed and identified actions carried out. | |

## The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

| | Y/N/Partial |
|---|---|
| The practice had adapted how it offered appointments to meet the needs of patients during the pandemic. | Y |
| The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access. | Partial |
| There were systems in place to identify and manage patients who needed a face-to-face appointment. | Y |
| The practice actively monitored the quality of access and made improvements in response to findings. | Y |
| There were recovery plans in place to manage backlogs of activity and delays to treatment. | Y |
| Changes had been made to infection control arrangements to protect staff and patients using the service. | Y |
| Staff were supported to work remotely where applicable. | Y |
| Explanation of any answers and additional evidence:<br>The practice had carried out an audit of the amount of appointments available to ensure they offered a suitable number.<br>There was an increased use of telephone and video consultations during the COVID-19 pandemic. We were informed that patients were all offered an initial triage appointment via the telephone with a clinician to see if a face-to-face appointment was necessary.<br>The practice increased the telephone lines coming into the practice to cope with the higher demand and had dedicated lines for outgoing calls.<br>Risk assessments of the building were made and changes implemented to ensure the safety of patients and staff.<br>The practice had a hearing loop within the premises. However, there was no further measures put in place to support patients who had a hearing impairment to access services. | |

**Appropriate and accurate information**

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

| | Y/N/Partial |
|---|---|
| Staff used data to monitor and improve performance. | Partial |
| Performance information was used to hold staff and management to account. | Partial |
| There were effective arrangements for identifying, managing and mitigating risks. | Y |
| Staff whose responsibilities included making statutory notifications understood what this entails. | Y |
| Explanation of any answers and additional evidence: | |

| |
|---|
| Data was available for the practice, for example, the Quality and Outcomes Framework (QOF) and information from Public Health England. However, the practice had not implemented sufficient actions to improve their performance from the previous inspection in September 2019. |

**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 (PPG). | Partial |
| 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:<br>The practice had a PPG although they had not been active as a group since the previous inspection in September 2019.<br>Plans had been made for the group to reconvene at the end of 2020. However, they had not been able to arrange for everybody to meet together.<br>The PPG lead had met with the new GP partnership in May 2021 to discuss plans for the future of the group. | |

Feedback from Patient Participation Group.

| Feedback |
|---|
| The PPG informed us they felt there had been positive changes in the practice and the new GP partnership were pro-active to continue to make improvements.<br>There was a new practice website that had a dedicated space for the PPG to communicate with the wider practice population. |

**Continuous improvement and innovation**

## There were 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:<br>At the September 2019 inspection, outcomes and learning from significant events and complaints were not shared with practice staff. There were no all practice staff meetings. There was a communication book in the reception office where some information was conveyed to staff. However, there was no record or indication that the information had been read by all staff. | |

At the May 2021 inspection, there were monthly practice meetings where outcomes and learning from significant events and complaints were shared with staff. The communication book had been replaced with the use of emails which provided an audit trail to show staff had been sent information.

**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.