East London
NHS Foundation Trust

REPORT TO THE TRUST BOARD IN PUBLIC

25 November 2021

Title	Care Quality Commission Inspection: October 2021
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Accountable Executive Director	Lorraine Sunduza, Chief Nurse and Deputy Chief Executive

Purpose of the report

- To provide the Board with an update on the recent Care Quality Commission (CQC) Well Led Inspection of the Trust including onsite inspections of older adults mental health inpatient wards and forensic services inpatient wards.
- To provide an update and report following a five-day comprehensive inspection by CQC at Leighton Road Surgery in October 2021 following which the service was rated Good with a Good rating in all five CQC domains.

Committees/meetings where this item has been considered

Date	Committee/Meeting
	NONE

Key messages

The CQC carried out inspections of Trust services in September and October 2021.

The inspections consisted of:

1. Mental health core service inspection of four older adult inpatient wards (London, Luton and Bedfordshire) 7-10 September 2021.
2. Mental health core services inspection of five forensic inpatient wards (medium and low secure) 14-16 September 2021.
3. Primary care inspection at Leighton Road Surgery (Bedfordshire) 4-8 October 2021.
4. Well-led desk top reviews and interviews of Trust leadership 26 and 27 October 2021.

Additionally, the CQC carried out a walkabout of adult and child and adolescent mental health services site in Newham on 15 October 2021. This was to review the progress of the work relating to quality and safety of the wards and the section 136 place of safety, and speak to staff and service users regarding their input, knowledge and progress of improvement plans.

CQC carried out the well-led' inspection on 26 and 27 October 2021. This consisted of interviews of the senior leadership team including Trust Board members and corporate leads, and also involved a number of desk top reviews. Throughout September 2021 CQC had observed committee meetings and held focus groups, looking at key areas including leadership, strategy, culture, governance, risk, information management and learning / improvement / innovation.

Leighton Road Surgery report has been received and the ratings have improved from 'inadequate with special measures' in 2019 to 'good' across all domains in October 2021. The CQC report is attached at appendix 1.

Initial headline feedback has been received following the well-led inspection and a full report with a rating and actions is expected by year end and will be presented to the next scheduled Trust Board when received.

Actions relating to these will be monitored via the Quality Assurance Committee with regular updates to the Board regarding progress.

Strategic priorities this paper supports

Improved population health outcomes	☒	
Improved experience of care	☒	
Improved staff experience	☒	
Improved value	☒	

Implications

Equality Analysis	The report does not include equalities analysis.
Risk and Assurance	Will provide with learning, innovation and continuous improvement as part of the quality assurance and quality improvement functions.
Service User/Carer/Staff	The focus of this report is the assessment of services and experience for users and carers
Financial	There are no direct financial implications associated with the report.
Quality	The report informs of CQC assessment of quality and the proposal aim to further support teams to understand and improve the quality of their service.

1.0. Background

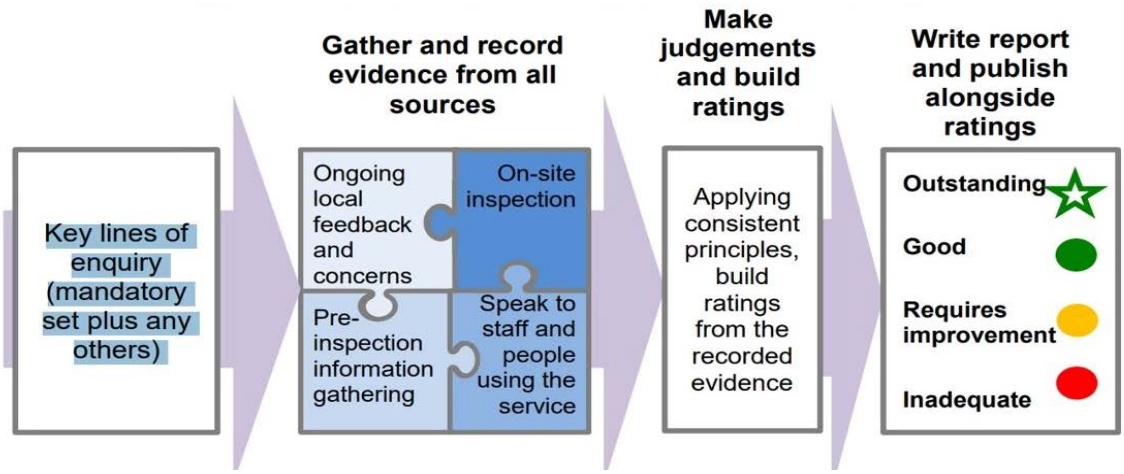
1.1 The CQC is independent regulator of Health and Social Care in England. Their role is to ensure that health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve.

1.2 The focus of their inspections is on the quality and safety of services; they ask five Key Lines of Enquiry (KLOE):

- Safe - are people are protected from abuse and avoidable harm. Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse
- Effective - does care and treatment and support achieve good outcomes, promotes a good quality of life and is based on the best available evidence
- Caring - that the service involves and treats people with compassion, kindness, dignity and respect.
- Responsive - do services meet people's needs
- Well-led - does the leadership, management and governance of the organisation assure the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.

1.3 These help the CQC to form a judgement about the quality of the service, determine a rating for each of the five key questions, and where relevant, produce an overall rating for the service.

1.4 Ratings are an important part of the inspection process and use a four-point scale: outstanding, good, requires improvement, or inadequate.



1.5 The Trust was rated Outstanding following inspections in 2016 and in 2018.

1.6 During the Covid-19 pandemic (from March 2020), the CQC paused routine inspections and focussed activity where there was a risk to people's safety. As a result of this, planned well-led inspections at ELFT for early 2020 did not take place.

2.0. Mental Health Core Service Inspections

2.1. In September 2021 inspections have taken place in four mental health wards for older people and five inpatient forensic services wards. The inspections followed a provider information request (PIR) relating to both services which required the services to submit various information including infection control audits and action plans; training, appraisal, supervision compliance; community meeting minutes; and serious incident and complaints information from the last 12 months.

2.2. Both inspections have included a pharmacy team carrying out further inspection activity on the same wards.

2.3. The Older People Wards

Team	Tuesday 7 September	Wednesday 8 September	Thursday 9 September	Friday 10 September
CQC Inspectors, CQC Professional Advisor and Expert by Experience	Leadenhall Ward	Cazabourn Ward Sally Sherman Ward	Fountain Court	Poplars Ward
CQC Pharmacy Inspector	Fountains Court Poplars Ward	Cazabourn Ward Sally Sherman Ward		

2.4. The Forensic Wards

Team	Tuesday 14 September	Wednesday 15 September	Thursday 16 September
CQC Inspector, CQC Professional Advisor and Expert by Experience	Clerkenwell Ward	Westferry Ward	Ludgate Ward
CQC Inspector, CQC Inspection Manager and Expert by Experience	East India Ward	Bow Ward	
CQC Inspector, CQC Inspection Manager, CQC Professional Advisor and Expert by Experience	Butterfield Ward	Clissold Ward	
CQC Pharmacy Inspector	John Howard Centre	Wolfson House	

3.0 Inspection of Leighton Road Surgery

3.1 An inspection of Leighton Road Surgery was also conducted by the CQC in October 2021. This was a separate process to the overall Trust well-led inspection, and each practice in the Trust is rated separately.

3.2 Information and evidence against the key lines of enquiry were presented to the CQC in advance of the inspection. The Executive Director for Primary Care delivered a presentation to the CQC focusing on the challenges and delivery at the practice over the preceding period which was followed by a question and answer session.

3.3 CQC were given access to the clinical system at the practice and conducted a number of searches remotely to check standards of clinical practice, record keeping, patient management against the domains of clinical safety and effectiveness.

3.4 The process also allowed for interviews with patients (represented by the patient participation group) interviews with receptionists, GPs, pharmacists, nurses and the practice manager. The national patients' feedback surveys, quality outcomes framework delivery, compliance with NICE and clinical standards form the other domains of inspections.

3.5 The inspector also inspected on site the facilities, compliance certification, staff records, immunisation and training records on site following which a preliminary feedback was received.

4.0 Well-led Inspection

4.1 CQC conducted a well-led inspection on 26 and 27 October 2021. This took place with the senior leadership team at Trust headquarters. The inspection involved a number of interviews/focus groups, looking at key areas including: leadership, strategy, culture, governance, risk, information management and learning / improvement / innovation.

4.2 Alongside interviews with Executive Directors, Non-Executive Directors and corporate leads the CQC observed committees and forums across the Trust throughout September and October as well as holding a series of focus groups.

4.3 The CQC attended and observed the following meetings:

Event/Group/Meeting	Date (2021)	Engagement
Forensics Medium Secure People Participation Working Together Group	2 September 11:00-12:30	Observing & 30 minutes at the end of the session to gain feedback
Council of Governors	9 September 17:00-19:00	Observing
People Participation Committee	16 September 14:00-16:00	Observing
ELFT Ability Network	16 September 12:00-13:45	Observing & 1 hour at the end of the session to gain feedback
Trust Board Meeting	23 September	Observing
Beds & Luton Community Health People Participation Working Together Group	23 September 16:00-17:30	Observing & 30 minutes at the end of the session to gain feedback
Newham CAMHS People Participation Working Together Group	27 September 17:00-18:30	Observing & 30 minutes at the end of the session to gain feedback
City & Hackney People Participation Working Together Group	29 September 15:00-16:30	Observing & 30 minutes at the end of the session to gain feedback

Event/Group/Meeting	Date (2021)	Engagement
Junior Doctors Forum	29 September 12:00-14:00	Observing & 1 hour at the end of the session for a focus group
People Participation Working Together Group for East London Psychology	11 October 13:30-15:00	Observing & 30 minutes at the end of the session to gain feedback
Mortality Review Group	19 October 15:00-16:00	Observing

4.4 The CQC also conducted a walkabout at Newham Centre for Mental Health (working age mental health inpatients) and the Coborn Centre (child and adolescent mental health inpatients and the section 136 place of safety). This was to review and interview staff about the progress of and their involvement in their respective improvement plans.

5.0 Feedback from the Inspection Process

5.1 The well-led full report and requested action will be presented to the next scheduled Trust Board when received. Initial feedback from the inspection process has commented positively on the Trust's culture, and progress since the last inspection, whilst confirming some areas of further improvement that are required.

5.2 The outcome of the inspection at Leighton Road Surgery has been received, and the overall rating of the practice has improved to 'Good'. When the surgery joined the Trust in 2019 it was rated as 'inadequate with special measures' and the improvement to a Good rating is testament to the efforts of both the surgery team and the primary care directorate within the Trust. A full copy of the report is attached as appendix 1.

5.3 Actions plans to address actions identified through the CQC inspections will be monitored via the Quality Assurance Committee with updates to the Board regarding progress.

6.0 Action being requested

6.1 The Board is asked to:

a) RECEIVE and **DISCUSS** the report.

Leighton Road Surgery

Inspection report

1 Leighton Road
Linslade
Leighton Buzzard
LU7 1LB
Tel: 01525372571

Date of inspection visit: 8 October 2021
Date of publication: N/A (DRAFT)

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Overall summary

We carried out an announced inspection at Leighton Road Surgery on 8 October 2021. Overall, the practice is rated as good.

The ratings for each key question are as follows:

Safe - Good

Effective - Good

Caring - Good

Responsive - Good

Well-led - Good

Following our previous inspection on 1 October 2020, the practice was rated Requires Improvement overall and for the effective, caring, responsive and well-led key questions and good for providing safe services:

The full reports for previous inspections can be found by selecting the 'all reports' link for Leighton Road Surgery on our website at www.cqc.org.uk

Why we carried out this inspection

This inspection was a comprehensive inspection to follow up on the findings from our inspection in October 2020, this included: the low numbers of mental health care plans completed, low cervical screening uptake and low levels of patient satisfaction with the service identified in the national GP patient survey.

How we carried out the inspection

Throughout the pandemic CQC has continued to regulate and respond to risk. However, taking into account the circumstances arising as a result of the pandemic, and in order to reduce risk, we have conducted our inspections differently.

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site. This was with consent from the provider and in line with all data protection and information governance requirements.

This included:

- Conducting staff interviews using video conferencing
- Completing clinical searches on the practice's patient records system and discussing findings with the provider
- Reviewing patient records to identify issues and clarify actions taken by the provider
- Requesting evidence from the provider
- A short site visit.

Our findings

Overall summary

We based our judgement of the quality of care at this service on a combination of:

- what we found when we inspected
- information from our ongoing monitoring of data about services and
- information from the provider, patients, the public and other organisations.

We have rated this practice as Good overall.

We found that:

- The practice had continued to make improvements to the service since our previous inspection, this was demonstrated through improvements in patient outcome measures and patient satisfaction.
- The practice provided care in a way that kept patients safe and protected them from avoidable harm. Although we did identify some areas the practice should improve.
- Patients received effective care and treatment that met their needs. Our review of clinical records found appropriate care and treatment was being provided.
- The practice was able to show how they had sustained and in some cases improved performance with regards to patient outcome data for patients with long term conditions, despite the challenges of the pandemic.
- The practice had made improvements in relation to the provision of services for mental health patients in particular; integrated working with the community mental health teams helped to deliver improved physical and mental wellbeing for this group of patients.
- The practice was committed to delivering quality improvement, we saw various projects in place to improve services for the practice population including work with some of the practice's most vulnerable patients.
- Staff were encouraged to learn and had opportunities to develop in their roles and responsibilities.
- Staff dealt with patients with kindness and respect and involved them in decisions about their care. The results from the latest National GP Patient Survey showed significant improvements in the patient experience from previous years.
- The practice adjusted how it delivered services to meet the needs of patients during the COVID-19 pandemic. Patients could access care and treatment in a timely way, patient satisfaction in relation to access showed significant improvement since our previous inspection.
- Complaints were acted on appropriately and in a timely way and used to make changes to the services.
- The way the practice was led and managed promoted the delivery of high-quality, person-centred care. The views of staff and patients were actively sought to deliver improvements and opportunities for learning encouraged.
- Governance arrangements supported the delivery of safe and effective care. Staff felt valued and motivated to deliver a high-quality service and deliver a comprehensive programme of quality improvement.

Whilst we found no breaches of regulations, the provider **should**:

- Identify all household members in the event of safeguarding concerns and ensure all staff are up to date with their safeguarding training relevant to their roles.
- Include checks against the NHS National Performers list when recruiting GPs.
- Implement regular fire drills and ensure staff are competent in the use of the evacuation chair.
- Implement systems to demonstrate the routine cleaning of clinical equipment.
- Review systems for monitoring patients prescribed high risk medicines to ensure test results and information required for effective prescribing are accurately recorded and that patients understand when to take their medicines.
- Improve systems for monitoring the competence of non-medical staff in extended roles For example, prescribing, consultations and coding and for monitoring role specific training.
- Improve uptake of cervical screening.

Overall summary

Details of our findings and the evidence supporting our ratings are set out in the evidence tables.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Population group ratings

Older people	**Not inspected**
People with long-term conditions	**Not inspected**
Families, children and young people	**Not inspected**
Working age people (including those recently retired and students)	**Not inspected**
People whose circumstances may make them vulnerable	**Not inspected**
People experiencing poor mental health (including people with dementia)	**Not inspected**

Our inspection team

Our inspection team was led by a CQC lead inspector who spoke with staff using video conferencing facilities and undertook a site visit. The team included a GP specialist advisor who spoke with staff using video conferencing facilities and completed clinical searches and records reviews without visiting the location.

A second CQC inspector also attended the site visit and joined some of the video conferencing calls.

Background to Leighton Road Surgery

Leighton Road Medical Centre is located in Leighton Buzzard at:

1 Leighton Road

Linslade

Leighton Buzzard

Bedfordshire

LU71LB

The practice has a branch surgery at:

Grovebury Road Surgery

Unit 6,7,8 Ridgeway Court,

Grovebury Road

Leighton Buzzard

Bedfordshire

LU7 4SF

Although Grovebury Road Surgery is registered as the branch site all patients were seen there with the exception of those undergoing minor surgical procedures which were undertaken at the practice's main site. The Leighton Road Surgery main site also hosted other services including ultrasound and out of hours services. During the inspection we visited both sites.

Since 2019 the practice merged with East London NHS Foundation Trust (ELFT) who provide management and clinical support to the practice through their primary care directorate. ELFT also provide support to several other practices in East London and Bedfordshire.

The provider is registered with CQC to deliver the Regulated Activities; diagnostic and screening procedures, family planning, surgical procedures and treatment of disease, disorder or injury.

The practice did not have a registered manager and was not registered for the regulated activity of maternity and midwifery services. These issues were discussed with the provider who advised that they were addressing them.

The practice is part of the NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group (CCG) and delivers a General Medical Services (GMS), this is a nationally agreed contract with NHS England, to a patient population of approximately 20,000.

The practice is part of a wider network of GP practices through the Leighton Buzzard Primary Care Network. A primary care network (PCN) is a group of GP practices working together to address local priorities in patient care.

Information published by Public Health England shows that deprivation within the practice population group as nine on a scale of one to ten. Level one represents the highest level of deprivation and level ten the lowest.

According to the latest available data, the ethnic make-up of the practice area is 95% white.

Clinical staffing consists of four salaried GPs and ten locum doctors, three pharmacists (all independent prescribers), eight nurses (including minor illness nurses and a complex care matron), and four Healthcare Assistants. Non-clinical staff include a practice manager and a team of reception and administrative staff.

The practice is registered as a partnership of two directors from the East London NHS Foundation Trust who provide direct leadership support to practice staff.

Due to the enhanced infection prevention and control measures put in place since the pandemic and in line with the national guidance, most GP appointments were telephone consultations. If the GP needs to see a patient face-to-face then the patient is offered a choice of either the main GP location or the branch surgery.

Leighton Road Surgery (main site) is open 8am to 5.30pm Monday to Friday. There is a Saturday morning surgery one Saturday every four weeks between 8am and 2pm.

Grovebury Road Surgery (branch site) is open 8am to 6pm Monday to Friday with extended opening until 8.30pm on a Tuesday evening and one Saturday per month.

When the practice is closed, out of hours services are accessed via the NHS 111 service.

Care Quality Commission

Inspection Evidence Table

Leighton Road Surgery (1-582132545)

Inspection date: 8 October 2021

Date of data download: 04 October 2021

Overall rating: Good

At our previous inspection in October 2020 we rated the practice as requires improvement. This was because:

- the provider was not meeting the 80% national target uptake for cervical screening and there had been a decline in cervical screening uptake from the previous year;
- the number of mental health care plans was below local and national averages and had also declined from the previous year; and
- results from the National GP Patient Survey were below local and national averages.

At this inspection we saw that the practice had made significant progress in improving the number of mental health care plans and improving services to patients with poor mental health; results from the latest National GP Patient Survey had improved in all areas and patient satisfaction was now in line with local and national averages. However, cervical screening uptake had remained similar to the previous year.

Safe Rating: Good

The practice was rated good at our previous inspection for providing safe services and remains good at this inspection. However, we identified areas the practice should improve including:

- Where safeguarding concerns are raised for patients, extending alerts on the practice clinical system to all household members.
- Include checks against the NHS National Performers list when recruiting GPs.
- Undertake regular fire evacuation drills and evacuation chair training.
- Implement systems to demonstrate the routine cleaning of clinical equipment.
- Review systems for monitoring patients prescribed high risk medicines to ensure test results and information required for effective prescribing are accurately recorded and that patients understand when to take their medicines.
- Establish systems for reviewing existing safety alerts to ensure actions are continued.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	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:

- There was a local lead GP for safeguarding children and adults with additional support from the Trust wide safeguarding lead. Staff we spoke with were aware who the safeguarding lead was and had access to safeguarding policies for support.
- Safeguarding was part of the providers mandatory training. Most staff were up to date and trained to an appropriate level, however we saw that there was a small number of clinical staff recently employed who were not up to date with their safeguarding training. Staff told us that there was a backlog for the safeguarding training due to the pandemic, but the staff had been identified for this training.
- There was a template to inform out of hours services of any information that needed to be shared.
- Alerts were used on the clinical system to ensure staff were aware of any safeguarding concerns although this did not extend to all household members.
- The practice held monthly safeguarding meetings for both children and vulnerable adults. These were attended by members of the community health and social care teams.
- Safeguarding concerns were discussed at the internal clinical liaison meetings held with all members of the clinical team, so they were aware. Staff we spoke with were able to give examples of recent safeguarding concerns and how they were managed and followed up.
- All practice staff were DBS checked.

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

Explanation of any answers and additional evidence:

- We reviewed the recruitment records for two clinical members of staff and saw appropriate checks were in place. We did however note that the provider did not routinely check GPs against the performers list when recruiting. The national performers list is a list of approved GPs who satisfy a range of criteria necessary for working in the NHS. The provider advised that they would include this in the future.

• The practice maintained records of staff vaccinations.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 06/05/21	Y
There was a fire procedure.	Y
Date of fire risk assessment: October 2020 Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: • We saw the fire procedure displayed throughout the practice. • The practice was able to demonstrate that fire alarms and equipment were regularly maintained and all staff had completed and were up to date with their fire safety training. There were also nominated fire marshals. However, records showed that fire drills had not been undertaken in the last 12 months. The practice also had an evacuation chair for patients with limited mobility but were unable to demonstrate that staff had received any training in its use. • Staff advised us of actions from the latest fire risk assessment that had been completed. For example, electrical installation checks, fridges moved from corridors and repairs to the alarm pull cord.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: July 2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: • There was a dedicated infection prevention and control lead for the practice and policies in place to support staff. • Training records reviewed showed all staff received training in infection prevention and control. • The premises were observed to be clean and tidy and regular infection control and cleaning audits were undertaken. • Staff were able to tell us about some of the actions that had been undertaken in response to the infection control audits which included a refurbishment of the premises. • We saw signed cleaning schedules for each room within the practice. Staff were expected to clean their own clinical equipment but did not maintain any specific records for the cleaning of clinical equipment. • Records reviewed showed appropriate arrangements in place for the removal of clinical waste.	

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:

- The practice relied on locum GPs to deliver the service but advised that many were long term locums who knew the service well. The locum GPs supported with tasks such as workflow.
- There was an induction pack to support locum staff who were new to the practice.
- Staff rotas were done three months in advance to ensure sufficient staff were on duty.
- The practice had undertaken work on demand and capacity to determine staffing needs and were working to develop the staff skill mix to help meet patient demand and needs. For example, GPs were supported by a pharmacy team, minor illness nurses and a complex care matron.
- The practice operated a duty doctor system in which reception staff could seek advice if needed. The practice was also involved in a recent two-week pilot where an A&E consultant sat with reception staff and advised whether patients were best seen in A&E or the practice.

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

Explanation of any answers and additional evidence:

- We found evidence of appropriate record keeping during our clinical records reviews.
- There was a dedicated admin team who undertook summarising of new patient records. We saw evidence that coding undertaken by the team had been audited although this was not in the last 12 months. Any findings from the audits were fed back to the individuals involved.
- The practice shared examples of referrals with us which contained appropriate information.
- Staff told us that workflow was cleared on a daily basis. Test results were reviewed by GPs.

Appropriate and safe use of medicines

The practice had 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) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.75	0.68	0.69	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2020 to 30/06/2021) (NHSBSA)	7.0%	10.6%	10.0%	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 and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2021 to 30/06/2021) (NHSBSA)	5.12	5.55	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	70.1‰	97.3‰	126.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	0.55	0.77	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	8.8‰	6.9‰	6.7‰	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

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Partial
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.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England 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
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:

- We saw medicines (including vaccines) and prescription stationery were stored securely onsite. There were systems in place for monitoring prescription stationery.

- During our site visit we reviewed two Patient Group Directions at random and Patient Specific Directions for the administration of medicines. These were in date and appropriately authorised.

- The pharmacists employed by the practice were independent prescribers and were involved in carrying out medicine reviews. We found medicine reviews seen during our inspection were well documented and thorough. The pharmacy team had regular supervision sessions with the medical director for primary care at the East London NHS Foundation Trust, they also participated in the clinical liaison meetings which occurred three times a week where they could discuss clinical cases with other members of clinical staff at the practice. However, there was no specific review of prescribing undertaken. The pharmacy team was relatively new and staff

Medicines management	Y/N/Partial

advised us that the provider planned to recruit a senior pharmacist to help with the clinical governance of the pharmacy team.

- Prescriptions generated by a locum GP were checked and authorised by a salaried GP.

- Our review of patients on disease-modifying antirheumatic drugs (DMARDs) and high-risk medicines found appropriate monitoring was largely in place however, we also found areas the practice could improve, which the practice agreed they would act on, for example:

- During the inspection we reviewed the clinical records for seven patients prescribed disease-modifying antirheumatic drugs (DMARDs) we found all patients were receiving regular monitoring. However, for one medicine (Methotrexate) the day of week for taking the medicine was not recorded which was not in line with best practice. For the second medicine reviewed (Azathioprine) four of the five records showed that the patient was being monitored in secondary care but did not record that the results had been checked or downloaded to inform effective prescribing.

- Our searches also identified seven patients prescribed Leflunomide in which the patients weight had not been checked in the last six months alongside the other monitoring that had been completed.

- We also reviewed patients prescribed a high-risk medicine (Warfarin). Of the five records we reviewed we identified two patients for whom the results of the blood checks were not recorded, in one case the blood check had been undertaken at the hospital and the other the patient was self-monitoring. Following the inspection, the practice advised that records had been amended to include the results.

- The practice undertook regular medicines audits including antibiotics and opioid prescribing and took part in local prescribing incentive schemes.

- The practice had systems for monitoring emergency medicines and equipment. All recommended emergency medicines were available but not all were included in the emergency checks. The practice advised that these were checked separately as part of the medicine stock checks and that staff were aware they were available in the medicine store.

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:	34
Number of events that required action:	34

Explanation of any answers and additional evidence:

- There were systems in place for recording incidents and sharing learning across the provider's practices. Staff we spoke with were aware of the systems in place and were able to give examples of learning from them.
- Incidents were discussed at the clinical governance meetings, attended by all staff. Actions from incidents were followed up to ensure they had been completed.

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

Event	Specific action taken
Patient on warfarin admitted to hospital with a high result.	The incident was investigated as staff felt the patient should have been identified earlier. It was found that the patient had cancelled two appointments because they had been unwell but staff had not picked this up as a new appointment was made. A new system was implemented and discussed with reception staff that if a patient wanted to cancel an appointment they notified the nurses so that they could contact the patient and if necessary undertake a home visit.
Pharmacy contacted the practice to query two medicines prescribed together where there was a risk of interactions.	The incident was investigated to identify how the two medicines had been prescribed together. The patient's medicines were reviewed and the incident discussed at the clinical governance meeting.

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

Explanation of any answers and additional evidence:

The practice had systems for receiving, monitoring and acting on safety alerts. The pharmacy team were largely responsible for running searches to identify patients affected and contact them.

Records were maintained to show what action had been taken in response to alerts.

While we saw that there were processes in place for managing new safety alerts these did not always extend to reviewing some existing safety alerts. For example, during the inspection we reviewed action taken by the practice in response to a medicine alert in which two medicines should not be prescribed together unless essential due to the potential for interaction between them. We reviewed five records of patients on the combination of these two medicines and found that it had not been identified in two out of the five cases. Following the inspection, the practice advised that action had been taken to address this.

Our review of patients on a medicine which can cause a risk of harm to unborn babies if taken by mothers found patients were being given appropriate advice about the risks and monitored appropriately.

Effective Rating: Good

At the last inspection in October 2020 we rated the practice as requires improvement for providing effective services this was due to the aggregation of requires improvement ratings for the population groups of working age patients and patients experiencing poor mental health.

At this inspection we found the practice had taken action to maintain cervical screening uptake and improve mental health outcomes for patients despite the challenges of the pandemic. We did however identify areas the practice should improve which included systems for maintaining records of role specific training, implementing formal systems for reviewing the competence of all clinical staff in advanced roles, improving the uptake of cervical screening and ensuring systems for reviewing do not resuscitate decisions as appropriate to ensure they remain relevant.

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y
Explanation of any answers and additional evidence:	

- We saw that evidence-based guidance was routinely shared and discussed at the clinical governance meetings.
- The practice held clinical liaison meetings, three times a week for clinical staff to bring clinical cases for discussion with their clinical colleagues.
- Our review of patient records found that evidence-based guidance was largely being followed and patients were receiving regular follow up of their medicines and conditions. Where patients had not attended for reviews, we saw contact had been made to encourage attendance. We saw evidence of appropriate and clear safety netting advice where appropriate if a patient's condition deteriorated. Where issues were identified the practice was quick to respond.
- The practice made use of templates when providing care and treatment to ensure a consistent approach and appropriate physical and mental health assessments were undertaken.
- Where possible staff had taken on lead roles to support patients' needs.

Effective care for the practice population

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 employed a complex care matron to support patients on their frailty register.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients.
- Patients eligible to have the meningitis vaccine, for example before attending university for the first time could request this.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. However due to the recent blood bottle shortage these were currently limited to physical health checks.
- All patients with a learning disability were offered an annual health check. There was a lead nurse for learning disability reviews. Data from the practice showed 77% of pateints on the learning disability register had received a review in the last 12 months.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. There was a lead GP for palliative care. We reviewed two palliative care plans during our inspection and found appropriate care planning information recorded.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice did not provide services for patients who misused substances but would signpost them to relevant services available locally.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. At our last inspection in October 2020 we identified mental health care planning as an area the practice should improve. For the year 2019/20 the percentage of completed care plans was 47.4% and had fallen since the previous year. At this inspection the practice advised that despite the challenges of the pandemic they had managed to improve QOF results for mental health indicators from 40% in 2019/20 to 98% in 2020/21. One of the pharmacists now took on the lead role for mental health reviews and our review of three mental health care plans showed patients care plans had been reviewed in the last 12 months.

- Patients with poor mental health, including dementia, were referred to appropriate services. The practice had set up a quality improvement project to improve the engagement with mental health services. Over the last year, monthly multi-disciplinary team meetings had been held with the mental health team to discuss patients and ensure their needs were being met. The latest GP National Patient Survey showed that 88% of patients felt the healthcare professional recognised or understood their mental health needs during their last general practice appointment, this was up from 71% in 2020. The latest results were in line with local and national averages.

Management of people with long term conditions

Findings

- The practice shared with us their latest QOF results which showed that they had continued to maintain and improve patient outcome scores across many long-term conditions indicators despite the challenges of the COVID-19 pandemic.
- 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.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Clinicians followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension carried out home blood pressure monitoring, the practice had blood pressure monitors that they could loan out if the patient did not have their own.
- Patients with COPD were offered rescue packs. There were limits to the number of rescue packs a patient could have before being invited for a review.
- Patients with asthma were offered an asthma management plan.

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	226	239	94.6%	Met 90% minimum

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)				
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)	220	232	94.8%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	220	232	94.8%	Met 90% minimum
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)	221	232	95.3%	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)	264	292	90.4%	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

Any additional evidence or comments

- The practice was meeting the minimum 90% for all five childhood immunisation uptake indicators. The practice was meeting the 95% WHO based national target of 95% (the recommended standard for achieving herd immunity) for one of the four childhood immunisation uptake indicators.
- Staff told us that the nursing team were involved in calling parents of children to attend for their immunisations as it had a better impact.
- The community midwifery team were located at the practice's Grovebury Road site.

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: 31/03/2021) (Public Health England)	72.8%	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)	76.7%	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)	61.7%	59.1%	63.8%	N/A
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)	39.8%	57.4%	54.2%	No statistical variation

Any additional evidence or comments

- At our last inspection in October 2020 we identified the uptake of cervical screening as an area the practice should improve. The uptake rate was 72.7% which was below the 80% national target. At this inspection the uptake of cervical screening was similar at 72.8%, there had been a decline during the pandemic but uptake was starting to improve in the latest quarter.

- Staff told us that they had reviewed the capacity needed to undertake cervical screening and had set up a dedicated clinic in response. There was a proactive recall system in place for patients who did not attend for their cervical screening.

- The uptake of other national cancer screening programmes (breast and bowel cancer) were in line with local and national averages.

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

- The practice had a clear commitment to quality improvement and had support from the wider East London Foundation Trust (ELFT) in driving this. Staff were able to tell us about various projects they were involved in and told us that they received protected time to undertake this work. This included: Multi-disciplinary team working with the community mental health services to improve mental and physical health of patients through better integration of care; review of staffing skill mix to meet patient demands, this included the recruitment of a complex care matron to support some of the practices most vulnerable patients; redesigning the prescription process.

- The practice shared with us various clinical audits they had undertaken over the last two years which included:

- A two-cycle audit reviewing the use of prophylactic antibiotics for acne and rosacea to ensure compliance with evidence-based guidance.

- A two-cycle audit of Direct Oral Anticoagulants (DOACs) to check patients were on the correct dose and monitoring had been completed.

- Several single cycle audits reviewing the prescribing of high dose opiates and opiates with high doses of Gabapentin and Pregabalin. Actions identified were to review patients and discuss treatment options.

Effective staffing

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

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

Explanation of any answers and additional evidence:

- The provider had clearly set out the mandatory learning requirements for staff and we found training up to date for most staff. The mandatory training records were maintained by the Trust.
- We saw examples of role specific training for staff but these were not held centrally or clearly monitored to ensure staff kept up to date with learning related to the roles they undertook for example in relation to long term conditions, cervical sample taking and immunisations.
- We saw that staff new to the service received an induction programme.
- There was a system of annual appraisals for staff to discuss their performance and learning and development needs. We saw examples of recent appraisals undertaken. Staff we spoke to told us how the practice was supportive of staff development and gave examples of this.
- Some of the clinical staff had extended roles for example, the pharmacy team were all independent prescribers and some of the nursing team ran minor illness clinics. The lead nurse undertook consultation audits for the nurse led minor illness clinics and all clinical staff participated in the three weekly clinical liaison meetings in which they could discuss patients seen. However, there was currently no consultation audits for the independent prescribers or medical input into the consultation audits for minor illness clinics. Staff told us that there were plans to recruit a senior pharmacist to oversee the pharmacists working in primary care.

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: The practice held monthly multidisciplinary team meetings with community health, mental health and social care staff.	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: • Patients had access to social prescribers and the practice ran weekly virtual coffee mornings. The coffee mornings were aimed at patients who were housebound and at risk of isolation. It provided armchair exercises, access to health and wellbeing support and social interaction. • Patients requiring support for smoking cessation and weight management were signposted to local services available. • In January 2020, prior to the pandemic the practice had delivered a health fair to the local community, providing health and wellbeing support and information. A further event was postponed due to the pandemic but was planned to be repeated in the near future. • Practice staff had helped in the delivery of the COVID-19 vaccination programme.	

Consent to care and treatment

The practice was able to demonstrate that it 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: • The practice undertook minor surgical procedures, we saw evidence of formal consent being obtained with evidence of risks explained.	

- Mental Capacity Act training was part of the provider's mandatory training for clinical staff and we saw that most staff had completed this.
- We reviewed three do not resuscitate decisions (DNACPR), there was evidence that these had been discussed with the patient or their representative and were appropriate. Only one of the DNACPR decisions had been completed by the GP practice but had not been reviewed in the last 12 months. The practice did not have copies of the DNACPR form where decisions were made by other services.

Caring Rating: Good

At our previous inspection in October 2020 we rated the practice as requires improvement for providing caring services because the results of the national GP patient survey were below local and national averages.

At this inspection we have rated the practice as good for providing caring services as there had been significant improvement in patient satisfaction. Results seen in the latest national GP patient survey were in line with local and national averages.

Kindness, respect and compassion

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

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

Explanation of any answers and additional evidence:

- The practice had carried out wellbeing checks for some of its most vulnerable patients during the pandemic and could access support from a social prescriber.
- The practice had been running a coffee morning since March 2021 to help improve the health and wellbeing of housebound and vulnerable patients. This provided a combination of exercise and social opportunities open to patients in the local area not just those registered with the practice.

Patient feedback	
Source	**Feedback**
Patient Participation Group (PPG)	We received complimentary feedback about the improvements that had been made at the practice.
NHS Website reviews	There were six reviews posted in last 12 months. Reviews were a mixture of positive and negative with no particular themes.
Online reviews	There were 55 online reviews, rating the practice as two stars out of five, nine reviews were made in the last 12 months. These were a mixture of positive and negative reviews with no particular negatives themes. With regards to the positive themes patients were complimentary about staff.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	88.4%	86.1%	89.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)	88.3%	85.2%	88.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	97.6%	94.4%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	76.6%	78.1%	83.0%	No statistical variation

Any additional evidence or comments
At our last inspection in October 2020 we identified patient satisfaction as an area the practice should improve. Results from the 2020 National GP patient survey were below local and national averages and had declined since the previous two surveys. Staff advised that at the time they had been rated as one of the worst practices in the CCG. At this inspection we saw significant improvements. All the indicators relating to patient experience had improved and they were now in line with local and national averages. For example, in the question relating to: • the health care professional being good at listening to them had increased form 73.1% in 2020 to 88.4% in 2021; • the health care professional treating them with care and concern had increased from 71.4% in 2020 to 88.3% in 2021; • the respondent had confidence and trust in their health care professional had increased from 89.3% in 2020 to 97.6% in 2021; and • the overall experience of the GP practice had improved from 44.9% in 2020 to 76.6% in 2021.

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

Any additional evidence
• The practice carried out monthly patient surveys and had received 1406 responses between January 2021 and September 2021. Questions were based on those used in the GP national patient survey and gave progress against the action plan to improve patient satisfaction. The practice shared information about action taken in response to comments received through their 'you said, we did' campaigns. • The practice involved patients in delivering improvements to the service for example, in the recruitment of new staff and with the prescription quality improvement project.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: • Results from the National GP Patient survey showed patients felt involved in decisions about their care and treatment.	

Source	Feedback
Patient Participation Group (PPG)	A representative from the practice's PPG told us that the practice involved them in decisions on quality improvement in the practice.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	91.8%	90.8%	92.9%	No statistical variation

Any additional evidence or comments
At the last inspection in October 2020 the practice had scored 81.1% in the national GP patient survey in response to the question about involvement in decisions about their care and treatment. At this inspection the practice had improved to 91.8% and was in line with CCG and national averages.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: • Staff were able to arrange for interpreters, when needed. • Information was recorded on the patient's clinical records if they had any special requirements. • The patient website contained information about local support groups available.	

Carers	Narrative
Percentage and number of carers identified.	511 (approximately 2.5% of the practice population)
How the practice supported carers (including young carers).	The practice had a dedicated carers champion to support patients who were carers. They liaised with local carers support organisations. Carers were offered flu vaccinations and health checks and were provided with information about support available to them. Where possible the practice would work around carers needs.
How the practice supported recently bereaved patients.	Staff advised that patients recently bereaved were contacted and offered an appointment if needed and a condolence card was sent.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive Rating: Good

At our previous inspection in September 2020 the practice was rated as requires improvement for providing responsive services because results from the National GP patient survey were lower than local and national averages for questions about access.

At this inspection the practice had made improvements in relation to patient satisfaction around access and responses in the latest national GP patient survey were in line with local and national averages.

Responding to and meeting people's needs

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

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

Explanation of any answers and additional evidence:

- The practice had a comprehensive quality improvement programme in place to improve services and meet patient needs. This had included work around demand and capacity and changes to systems and processes in response to patient feedback.
- Where possible the practice tried to ensure continuity of care for long term conditions. The skill mix of staff had been considered in how to best meet patients' needs and support the work of the GPs.
- Home visits were undertaken where patients were unable to attend appointments due to their vulnerability and health needs. Wellbeing checks were also undertaken to identify any additional patient needs.
- The Leighton Road Surgery had two sites at Leighton Road (registered with CQC as the main site) and Grovebury Road (registered with CQC at the branch site). With the exception of minor surgical procedures all patients were seen at Grovebury Road. We found the premises at Grovebury Road well maintained, patients were seen on both the ground and first floor with lifts in place for patients to access the first floor. The Leighton Road Surgery was due to undergo refurbishment with plans to use as offices for the service.
- The practice had a hearing loop on site and patients could request information in specific formats if needed.

Practice Opening Times	
Day	**Time**
Opening times: Grovebury Road	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm (extended opening hours 6.30pm to 8pm)
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Appointments available:	
Monday to Friday	Telephone appointments, face to face appointments, video consultations, walk-in phlebotomy clinics and home visits.
	Extended access appointments were also commissioned by the CCG evenings and weekends.

Further information about how the practice is responding to the needs of their population
• Patients with specific health needs had a named GP who supported them in whatever setting they lived. • The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. • In recognition of the religious and cultural observances of some patients, the GP would respond quickly, where possible, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred. • The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues. • Nurse appointments were available until 6pm daily for school age children so that they did not need to miss school. • All parents or guardians calling with concerns about a child were offered a same day appointment when necessary. The practice offered a daily clinic between 4pm and 6pm specifically for children who become ill during the day. • The practice was open until 8pm on a Tuesday. Pre-bookable appointments were also available to all patients at additional locations within the area in the evenings and at weekends, through a CCG commissioned service. • People in vulnerable circumstances were able to register with the practice, including those with no fixed abode such as homeless people and Travellers. • The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

People were able to access care and treatment in a timely way.

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	Y/N/Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Patients were able to make appointments in a way which met their needs.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
There were systems in place to support patients who face communication barriers to access treatment.	Y
Patients with urgent needs had their care prioritised.	Y
The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.	Y

Explanation of any answers and additional evidence:

- The practice website contained information about practice opening times, services available and how to make an appointment.
- The practice had reviewed the appointment system to same day, one day and three day appointments and had found this had helped reduce appointments lost through non- attendance.
- Staff advised that patient specific needs were recorded on the patients records so that they could be accommodated where possible.
- The practice had a wide skill mix of staff that worked alongside the GPs, these included pharmacists who supported with medicine reviews, nurses undertaking long term condition reviews and minor illness clinics, complex care matron supporting vulnerable and elderly patients, social prescribers and more recently a mental health practitioner.
- A duty doctor system ran daily to pick up any urgent calls and appointments.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	64.2%	N/A	67.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	63.6%	63.1%	70.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	60.1%	60.1%	67.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	74.9%	77.0%	81.7%	No statistical variation

Any additional evidence or comments
Questions relating to access in the latest National GP Patient Survey were mostly in line with local and national averages. The practice had made significant improvement on patient satisfaction with access despite the challenges caused by the pandemic since the previous survey in 2020. For example. • The question relating to ease of getting through to the practice on the phone improved from 23.1% in 2020 to 64.2% in 2021; • The question about overall experience of making an appointment improved from 30.2% in 2020 to 63.6% in 2021; • The question about satisfaction with appointment times had improved from 25.4% in 2020 to 60.1% in 2021; and • The question about the satisfaction with the appointment they were offered improved from 49.5% in 2020 to 74.9% in 2021.

Source	Feedback
NHS website and other online reviews	We saw some negative comments about access in a small number of reviews.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	77
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Explanation of any answers and additional evidence:

- The complaints process was available to patients on the practice website. This set out how to raise a complaint, expected timescales for a response and support available in raising a complaint.
- The practice was able to provide examples of changes they had made in response to complaints for example the practice had reviewed the prescription process to make it easier for patients. Patients had been consulted in the process.
- Complaints were reviewed and discussed for themes and trends as a standing agenda item at the Clinical Governance Meetings.
- We reviewed two complaints received within the last 12 months and found these had been investigated and responded to in a timely manner. Patients were informed as to how they could escalate their concerns if they were unhappy with the practice's response to their complaint.

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient unhappy that their referral was routine and not urgent.	The complaint was investigated and discussed with the GP. The patient received an explanation for the decision.
Patient had not received a call back.	The call back related to a clinic that wasn't managed by the practice. The complaint was acknowledged and the patient informed.

Well-led Rating: Good

At our previous inspection in October 2020 the practice was rated requires improvement for providing services that were well-led because clinical indicators for mental health care plans and cervical screening remained lower that local and national averages. GP patient scores were also lower than local and national averages and action taken had yet to impact on patient outcomes.

At this inspection we found significant improvements had been made in relation to mental health indicators and in patient satisfaction with the services. Cervical screening uptake had been maintained despite the challenges of the pandemic but was still below the national target.

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:

- Since 2020 the practice has worked in partnership with the East London NHS Foundation Trust (ELFT) primary care directorate. This has helped provide additional leadership capacity and resilience to the practice.
- Quality improvement was prominent on the practice agenda to address the challenges faced by the practice which had led to their inadequate CQC rating in 2019.
- The practice shared with us their quality improvement programme which has focused on streamlining systems and processes, managing demand and capacity for the service, reviewing staffing and skill mix to meet patient needs, improving patient satisfaction and mental health support. The practice was also able to demonstrate the impact of those changes in terms of patient satisfaction and improved patient outcomes, in particular with mental health.
- Staff found leadership both within the practice and the wider trust approachable and had opportunities to develop in their roles.

Vision and strategy

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

	Y/N/Partial

The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y

Explanation of any answers and additional evidence:

- Staff we spoke with were able to articulate the vision and values of the practice to us. Staff felt very much involved in the planning and development of the services and were encouraged to generate ideas for improvement.
- Away days were held to identify priorities for action and staff received protected time to implement actions needed.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y

Explanation of any answers and additional evidence:

- Staff told us that there was a strong learning culture in the practice and they were encouraged to report incidents. We saw that shared learning and discussion were very much the format of practice meetings and that these were inclusive of all staff.
- Staff were given time to learn and develop in their roles to support high quality sustainable care. Staff had the support from colleagues and the wider trust.
- Staff wellbeing was a priority and there was a wellbeing champion for the practice. Staff told us that they worked well as a team and this was evident through the inclusive meetings in which staff had opportunities to share clinical cases and learn from each other.
- Staff were aware there was a whistle blowing policy in place and where to find it, this included a named freedom to speak up guardian.
- Staff were able to give examples of duty of candour in which patients received an apology when things went wrong.
- Equality and diversity training was part of the provider's mandatory training. Training records showed all staff had completed this training.

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

Source	Feedback
Staff interviews	Staff we spoke to told us how they had come through a difficult time where staff morale had been very low. They told us how the impact of negative feedback

	through the media and face to face had affected them. Staff told us how things had significantly changed and spoke about being motivated and valued. They felt the changes and new governance arrangements made the practice feel much safer. Staff were encouraged to be open and honest and to learn when things went wrong.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y

Explanation of any answers and additional evidence:

- There was a practice leadership team responsible for the day to day running of the service with support from the East London NHS Foundation Trust (ELFT) for many of the back-office functions such as human resources.
- The practice held regular governance meetings which were inclusive of all staff.
- Staff we spoke with were clear about their roles and responsibilities and took on lead roles.
- Policies and procedures were available to staff from their computers.

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:

- At our previous inspection in October 2020 we saw that the practice had in place clear action plans to improve clinical indicators but had yet to fully embed them. Patients survey results were also low for patient satisfaction with the service. At this inspection we saw that patient outcome data and patient satisfaction was showing demonstrable improvements from the previous year, despite the ongoing challenges from the pandemic.

- Quality improvement projects such as the mental health integration project were in progress improving outcomes for patients with poor mental health.

- Although clear improvements in cervical screening uptake had yet to be demonstrated, uptake had been maintained despite the pandemic.

- The practice had a business continuity plan in place and held contact details for services and staff in the event of disruption to service provision.

- Performance and risks were discussed at the regular clinical governance meetings. Being part of ELFT enabled the practice to share risks with other practices so that they could also learn from each other.

- Staff had opportunities for regular appraisals in which their individual performance could be discussed.

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.	Y
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:

- Staff advised us that any patient that needed to be seen in person would be booked in. We saw from the national GP patient survey that patient satisfaction in relation to access had improved significantly since 2020 and was in line with local and national averages. Capacity and demand for staffing was regularly reviewed and rotas planned in advance to ensure there were sufficient staff to meet patient need.

- Patients who might be digitally excluded could still access appointments by telephone. Staff undertook home visits to their most vulnerable patients and employed a complex care matron to work with patients who were potentially isolated to ensure their care needs were met. Online coffee mornings had also been introduced to encourage those who were frail and isolated to maintain some activity and provide social interaction, the practice could loan out equipment for anyone who did not have a computer to participate in the coffee mornings and were shown how to use it.

- The practice had introduced various measures to protect staff and patients through the pandemic, this included a one-way system, temperature checks and the provision of hand sanitiser for patients to use.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence: • We saw that the practice's quality improvement plans were used to identify priorities for action, there was a focus on some of the practice's most vulnerable patients. • We saw audits and risk assessments were used to identify areas of potential risk and action taken in response. • Complaints and incidents were used to support learning and improvement and drive change.	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Explanation of any answers and additional evidence:	

- The practice had an information governance and information management and technology security policy in place.
- We saw evidence that the practice was registered with the Information Commissioner's Office.
- There were security and confidentiality arrangements for staff working remotely.

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Explanation of any answers and additional evidence:

- The practice was able to provide examples of how they had reviewed systems and processes in response to patient feedback on the services. For example, prescription processes.
- There was an active patient participation group (PPG) who were encouraged to be involved in improving the services. For example, to test out changes to systems and processes and be involved in the recruitment of new staff. There were approximately 18 members of the PPG representative of the local community. Meetings had continued throughout the pandemic.
- Staff were involved in planning and delivering the services, this was evident through the various quality improvement events and projects. Staff were able to provide examples of ideas they had put forward which had been implemented such as the re-introduction of the walk-in blood clinic.
- The practice was working with external partners to improve services to patients for example, the integrated mental health project.

Feedback from Patient Participation Group.

Feedback
The representative from the patient participation group we spoke with told us that the practice had changed for the better, they felt listened to and valued as group.

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:	

- There was a strong focus on learning and improvement within the practice. Information and feedback received was used to identify areas for improvement.

- There was an audit programme in place aimed at improving the care patients received and ensuring safe services were provided.

- Staff had opportunities to discuss and learn from incidents and their own performance through the appraisal process.

Examples of continuous learning and improvement

- The practice shared with us some of the projects that they had put in place to support improvement. These included:

- The integrated mental health project in which relevant services have come together to help meet the needs of patients with poor mental health in a joined-up way.

- Process mapping of systems for blood tests and prescriptions to ensure these run effectively.

- Weekly virtual coffee mornings, providing vulnerable patients at risk of isolation with opportunities to participate in gentle exercise, receive support on various health and well-being issues and have opportunities for social interaction. Patients were supported and loaned technology to enable them to participate when needed.

- Development of a diverse skill mix within the workforce to best meet the needs of patients.

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.
-
- ‰ = per thousand.