

# Care Quality Commission

## Inspection Evidence Table

### The Forest Surgery (1-543625414)

#### Inspection dates:

**26 August 2021: On-site visit**

**31 August 2021: Remote clinical records review**

**Date of data download: 28 July 2021**

#### Overall rating:

At our previous inspection on 20 November 2019 we rated the practice as requires improvement overall as we identified issues with:

- exception reporting
- patient satisfaction
- mitigating risks
- the sharing of learning
- staff training.

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

#### Safe

#### Rating: Inadequate

**At our previous inspection on 20 November 2019 we rated the provider as requires improvement for providing safe services because we found concerns regarding:**

- The systems for sharing and documenting learning from significant events and patient safety alerts was not effective.
- Insufficient documentation in the way of action planning for risk assessments.
- Staff were not adequately trained for lead roles in infection control or fire safety.

**At this inspection on 26 and 31 August 2021, we found new concerns regarding:**

- Safeguarding systems including training for non-clinical staff.
- The system for documenting patient safety alerts had been in operation since March 2021 and historical patient safety alerts that remained clinically relevant had not been included.
- The management of patients who are prescribed high-risk medicines and medicines that require additional monitoring.
- Missed diagnoses for patients who may have Type Two Diabetes.

- Failsafe processes to follow-up patients who have been referred as a two-week wait urgent referral and female patients who have undertaken cervical screening.
- The safe effective management of patient group directions.
- The safe effective management of emergency medicines and equipment.
- The provider could not demonstrate they operated safe premises practices, including fire safety.
- Not all significant events had been recorded.

**At this inspection on 26 and 31 August 2021, we found the provider had made improvements regarding:**

- The provider had made progress and reduced its rates of exception reporting.
- The systems for sharing learning with staff, from significant events and patient safety alerts.

### Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial 1
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies and procedures were monitored, reviewed and updated.	Partial 2
Partners and staff were trained to appropriate levels for their role.	Partial 3
There was active and appropriate engagement in local safeguarding processes.	Partial 4
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial 4
<ol style="list-style-type: none"> <li>1. We were not assured that safeguarding systems and practices were fully developed and implemented in a way that kept people safe.</li> <li>2. The provider could not demonstrate that practice policies were regularly reviewed and updated as required. For example, the safeguarding policies did not reference female genital mutilation (FGM), of the legal requirement to report this and of the necessity to undertake safeguarding risk assessments for children whose mother may have been affected by FGM. Or if they suspected that a female child may be at risk of FGM. The provider had not referenced the recent intercollegiate guidance update regarding training requirements for some clinical and non-clinical staff and policies did not contain up to date information. Following the inspection, the provider submitted evidence of a policy relating to FGM and FGM risk assessment</li> </ol>	

Safeguarding	Y/N/Partial
<p>templates. We will review safeguarding policies and procedures at our next inspection to check how this has been embedded into practice systems.</p> <ol style="list-style-type: none"> <li>We reviewed evidence that all seven clinical staff members had undertaken adult safeguarding training. However, we found that six out of the seven clinical staff members had undertaken safeguarding training for children at the appropriate level. We also found that none of the eleven non clinical staff had undertaken safeguarding training for adults and children at the level appropriate to their role.</li> <li>The provider submitted limited evidence of active and local engagement with local safeguarding processes. For example, one email regarding communication with a school nurse. They could not demonstrate they had attended meetings, whether on a face to face basis or online, to meet the blended learning requirements for safeguarding leads and to discuss vulnerable adults and children who may be at risk. We are not assured of patient safety. Following the inspection, the provider submitted evidence of a follow-up letter regarding a safeguarding referral they had made. We will check safeguarding systems at our next inspection to review any improvements that have been made.</li> </ol>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial <sup>1 2</sup>
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	N <sup>3</sup>
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	N <sup>4</sup>
<ol style="list-style-type: none"> <li>We reviewed the provider's policy and protocol regarding recruitment and identified gaps within this. It did not state how many references were required and if they should be employment and/or personal references. It contained an old reference to a criminal records bureau check and the reference template did not enquire as to what period of time the candidate had been in their employment, for employer references.</li> <li>We reviewed six staff files and identified gaps within these recruitment records. For example, the DBS check for the recently recruited locum advanced nurse practitioner (ANP) expired on 09 August 2021. Three out of six staff records did not contain references.</li> <li>We reviewed 13 staff records regarding staff vaccination and found that eleven out of thirteen staff did not have certificated immunity or vaccinations in line with national guidance.</li> <li>We reviewed staff files for three clinical staff and found the provider did not have a safe effective system for three out of three staff, regarding the monitoring and management of up to date professional registrations information. For example, records held for a GP were dated 2017, for a (ANP) who had been recently recruited, records dated from 2015 and for a Clinical Pharmacist 2014.</li> </ol>	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person.	Partial

Date of last inspection/test:	25 March 2021 <sup>1</sup>
There was a record of equipment calibration. Date of last calibration:	Partial 25 March 2021 <sup>1</sup>
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Partial <sup>2</sup>
There was a fire procedure.	Y
A fire risk assessment had been completed. Date of completion:	Y <sup>3</sup> 16 June 2020
Actions from fire risk assessment were identified and completed.	Y <sup>3 4</sup>
<ol style="list-style-type: none"> <li>1. The provider submitted evidence to demonstrate they had undertaken portable appliance testing (PAT) and calibration of electrical and clinical equipment, in line with national guidance. However, we identified some pieces of equipment that had not been PAT tested. For example, back-up petrol generator.</li> <li>2. The provider submitted evidence of two substances they had identified as potentially harmful to health. For example, a detergent and dishwasher tablets. We identified additional substances on the practice premises that had not been included in the COSHH risk assessment. For example, the medium used to transport cervical screening samples.</li> <li>3. We reviewed remedial actions that had been identified in the provider's fire safety risk assessment and saw they had been completed. For example, the installation of emergency lighting.</li> <li>4. We reviewed evidence that three out of twenty-two staff had not undertaken fire safety training. The provider had identified four members of staff to act as fire wardens in the event of a fire.</li> </ol>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	Partial 09 August 2021 <sup>1</sup>
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Y 09 August 2021 <sup>2</sup>
<ol style="list-style-type: none"> <li>1. The provider submitted evidence of an Annual Health and Safety Review and health and safety risk assessments in accordance with their policy. For example, for consultation rooms and home visits. Staff had access to a Health and Safety Employee handbook which stated that staff were able to report any hazards anonymously if they wished. However, we identified two pieces of equipment that had not been risk assessed. For example, a power logger and a back-up petrol generator. Risk assessments had not been completed for this equipment and there was no evidence of any actions they were required to undertake and if these actions had been completed.</li> <li>2. The provider could demonstrate evidence they had undertaken a legionella risk assessment and that follow-up action points had been completed. For example, the practice lead for the management of legionella had undertaken appropriate training.</li> </ol>	

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were generally met.**

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Partial 1
Infection prevention and control audits were carried out. Date of last infection prevention and control audit:	Partial 2
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<ol style="list-style-type: none"> <li>1. We reviewed evidence that two out of nineteen staff had not undertaken infection prevention and control training.</li> <li>2. The provider could demonstrate they had undertaken an infection prevention and control audit. However, they could not demonstrate undertook regular cleaning audits to help prevent and mitigate the risk of healthcare acquired infections related to the practice premises. Following the inspection, the provider submitted two infection prevention and control (IPC) policy statements, one of which was blank, and IPC for GP practices guidance. We will review this at the next inspection to check whether the gaps we have identified have been resolved and embedded into practice systems.</li> </ol>	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y 1
There was an effective induction system for temporary staff tailored to their role.	Partial 2
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y 3
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.	Partial 4
<ol style="list-style-type: none"> <li>1. We interviewed staff and saw that the provider had an effective approach in place to manage peak business times and when staff were on holiday or otherwise away from the practice.</li> <li>2. We reviewed six staff files and saw that three out of six records did not contain information regarding an induction. Following the inspection the provider submitted evidence of an induction pack for new employees, new Employee Recruitment, Selection, Interview &amp; Appointment Policy &amp; Protocol and an Induction Acknowledgment Form. We will review this at our next inspection.</li> <li>3. We saw the provider had appropriate equipment in place to manage medical emergencies. However, this equipment was stored in locked cupboards in four separate locations. This is not in line with national guidance and has the potential to delay a response in an emergency situation.</li> </ol>	

4. We interviewed staff who told us they would call a GP immediately if a patient presented at reception as being unwell and would call for an urgent ambulance if asked to do so by a doctor. However, the provider could not demonstrate their administration staff had undertaken sepsis training or other training regarding red flag signs and medical emergencies. We reviewed training records and found that ten out of eleven reception/administration and one clinical member of staff had not completed sepsis training.

#### Information to deliver safe care and treatment

#### Staff did not always have 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.	Partial <sup>1</sup>
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
1. The provider had a system in place regarding two-week wait urgent cancer referrals and cervical screening. However, these were not failsafe systems. They did not submit evidence of any audits they had undertaken to check that all patients who had been referred had been followed up and seen in secondary care. Following the inspection, the provider submitted evidence that they had implemented failsafe processes.	

#### Appropriate and safe use of medicines

#### The practice did not have failsafe 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	0.49	0.54	0.70	Tending towards variation (positive)

Indicator	Practice	CCG average	England average	England comparison
PU) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)				
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2020 to 31/03/2021) (NHSBSA)	13.0%	11.1%	10.2%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2020 to 31/03/2021) (NHSBSA)	6.40	5.85	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	85.4‰	64.1‰	126.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	0.40	0.53	0.66	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	4.5‰	5.4‰	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.	Not assessed
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	N
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 1
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

Medicines management	Y/N/Partial
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.	Partial 2
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.	Not applicable
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.	Partial 3
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
<ol style="list-style-type: none"> <li>1. Staff told us they had regular access to discussions with a GP. However, the provider could not demonstrate they undertook formal clinical supervision with a non-medical prescriber employed in the practice and that any meetings were minuted. Following the inspection, the provider submitted evidence of a formal clinical supervision meeting on 06 September 2021 with a member of staff.</li> <li>2. We reviewed the system and process the provider had in place to monitor and manage medicines, including high-risk medicines. The provider could not demonstrate they operated a safe effective system regarding the management of medicines which required additional monitoring. For example, we found evidence that patients had not undertaken appropriate blood and additional monitoring for high-risk medicines including medicines used to treat hypertension, oedema and auto-immune conditions. Because of this we were not assured regarding patient safety.</li> <li>3. We found the emergency medicines and equipment kit held a stock of medicines and equipment which were regularly checked. However, we found it was not completely maintained in line with national guidance. For example, the provider did not maintain a supply of a medicine used to treat croup in children. The provider had not conducted a risk assessment as to why they did not stock this medicine. Emergency medicines and equipment were not stored in line with national guidance and had the potential to delay a response in an emergency situation.</li> </ol>	



## Track record on safety and lessons learned and improvements made

The practice had a system to learn and make improvements when things went wrong. However, this was not always effective.

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.	Partial <sup>1 2</sup>
There was evidence of learning and dissemination of information.	Partial <sup>3</sup>
Number of events recorded in last 12 months:	5
Number of events that required action:	5
<p>1. The provider had a system in place regarding significant events. However, the provider could not assure us they had a consistent approach to sharing all relevant information with external agencies. For example, they could demonstrate they shared one significant event, which was dated within the past two months, with the national reporting and learning system (NRLS) and the local GP Federation and Clinical Commissioning Group (CCG). We saw that contact information regarding the Adverse Incident Centre, as included in the practice policy, was no longer current information.</p> <p>2. The provider could not demonstrate they comprehensively recorded and reviewed all significant events. For example, we reviewed information that not all significant events were recorded. In addition, we reviewed information submitted by the provider and during our interviews with staff, regarding a needlestick injury that had occurred. This did not include what immediate action staff had taken to treat the sharps injury that had occurred and any follow-up actions arising from the incident. We will review the effectiveness of the practice system at the next comprehensive inspection.</p> <p>3. We found the provider had made improvements since our last inspection regarding developing a system for sharing learning with staff. We saw that staff were informed regarding any learning events that had been recorded and that staff were required to sign to say they had received and read the information concerned.</p>	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Needlestick injury	A clinical member of staff had incorrectly disposed of a used needle and a member of support staff had discovered this. This was discussed at a practice meeting and it was agreed that in future needles and sharps will be disposed of immediately after use into an appropriate sharps bin.
A practice email inbox had not been permanently closed potentially allowing important results and letters to build up unchecked.	The practice was alerted that an email inbox had not been permanently closed as they had believed it had. It was agreed that in the future event of an email box being closed, regular checks should be made to be assured this had been completed.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
<p>1. We reviewed evidence that the provider had developed a system to monitor and manage patient safety alerts since March 2021. However, this did not include historical medicines alerts that remain relevant regarding the management of high-risk medicines. For example, a previous alert regarding the concurrent prescribing of medicines used to treat patients with a high blood cholesterol, did not have on going or repeat audit. Following the inspection, the provider submitted information to demonstrate that they operated a dual system regarding the management of patient safety alerts and had undertaken monitoring and medicines searches on 03,04 and 11 August 2021.</p>	

## Effective

## Rating: Inadequate

**At our previous inspection on 20 November 2019 we rated the provider as requires improvement for providing safe services because we found concerns regarding:**

- High levels of exception reporting and the practice did not have adequate explanations for this or a plan to reduce this. (Exception reporting is the removal of patients from the figures where, for good reason, they are not treated in line with the usual guidance. This has since been replaced by personal care adjustments (PCA)).
- The practices uptake of childhood immunisations was below the national target.
- Uptake for cervical screening was below the national target.

**At this inspection on 26 and 31 August 2021 we found the provider had made improvements regarding:**

- The provider had made improvements regarding exception reporting and that exception reporting rates are now in line with local and national levels.

**At this inspection on 26 and 31 August 2021 we found concerns regarding:**

- Care and treatment was not consistently delivered in line with national guidance.
- Childhood immunisations achievement rates had remained low.
- Cervical screening achievement rates had remained low.
- The provider could not demonstrate they had a comprehensive programme of quality improvement in place and used information about care and treatment to drive improvements in patient care.
- A clinical indicator regarding blood monitoring for patients with type two diabetes was tending towards a negative variation.
- The provider could not demonstrate that clinical staff had undertaken appropriate core specific training.
- The provider could not demonstrate they had undertaken appropriate clinical supervision with clinical staff.
- The provider could not demonstrate they had undertaken regular annual appraisals with staff.
- The provider could not demonstrate how they supported national priorities and initiatives to improve the population's health.
- The provider had not sufficiently improved their systems for sharing and documenting learning from significant events and patient safety alerts. This was not always effective.
- Minutes from clinical and practice meetings was scanty and lacked detail. There was no standing agenda, action points that had been identified and demonstration of follow-up of action points
- Staff training regarding basic life support, fire safety and information governance.

**These areas affected all population groups, so we rated all population groups as inadequate for providing effective services.**

**Effective needs assessment, care and treatment**

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Partial 1
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial 1 2
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial 3
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial 4
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
<ol style="list-style-type: none"> <li>1. We reviewed a sample of care plans for four patients who have been diagnosed with serious mental illness or dementia and found all four care plans contained an appropriate review and information.</li> <li>2. When we spoke with the provider, they told us they were aware of national guidance regarding patient care and treatment. However, We identified 14 patients who had been prescribed a medicine used to treat oedema (fluid build-up in the body).We reviewed a sample of five out of fourteen patient records and found concerns with four out of five records and saw that national guidance was not consistently followed. For example, we reviewed evidence that several medicines were prescribed for three patients who had several co-morbidities. We are not assured regarding patient safety.</li> <li>3. We reviewed practice achievement data regarding patients who had been referred to secondary care as an urgent two-week wait referral, which was in line with local and national achievement levels for this indicator. However, we found the provider did not operate a fail-safe follow-up system regarding two-week-wait referrals. They had not undertaken any audits to assure themselves that all patients who had been referred via this pathway, had been followed up.</li> <li>4. We undertook a search on the provider's clinical system for a medicine used to treat hypertension and this medicine requires regular blood monitoring for patients. We saw that 100 patients had not had up to date blood monitoring and we sampled five patient records. We have concerns for five out of five patients who are prescribed this medicine.</li> </ol>	

## Older people

## Population group rating: Inadequate

### Findings

- The provider told us they undertook home visits and telephone consultations for older people when required.
- The provider told us they participated in regular multidisciplinary meetings with other healthcare professionals to discuss patients at-risk and nearing end-of-life. However, notes from clinical meetings contained little detail, including which professionals were present. The provider did not submit evidence regarding end of life care meetings. Following the inspection, the provider submitted evidence of an appropriate meeting template which included a tracker to follow up any action points.
- The provider could not demonstrate how they had assessed the needs of their patient population. For example, there was limited practice nurse provision at the practice, which may have impacted on long term condition management for this patient population group. They could not demonstrate that clinical staff had been appropriately trained and competency checked.
- Staff told us that due to the Covid-19 pandemic, health checks had been put on hold.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

## People with long-term conditions

## Population group rating: Inadequate

### Findings

- The provider could not demonstrate how they had assessed the needs of their patient population. For example, there was limited practice nurse provision at the practice. They could not demonstrate that clinical staff had been appropriately trained and competency checked.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	80.5%	77.5%	76.6%	No statistical variation
PCA* rate (number of PCAs).	1.3% (6)	7.0%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	92.3%	88.4%	89.4%	No statistical variation
PCA rate (number of PCAs).	2.5% (2)	6.8%	12.7%	N/A

\*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	82.1%	85.1%	82.0%	No statistical variation
PCA* rate (number of PCAs).	1.9% (2)	2.9%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	54.7%	62.4%	66.9%	Tending towards variation (negative)
PCA rate (number of PCAs).	3.4% (12)	10.2%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	77.7%	75.4%	72.4%	No statistical variation
PCA rate (number of PCAs).	2.2% (14)	5.1%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	88.2%	89.2%	91.8%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	4.7%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	82.7%	79.0%	75.9%	No statistical variation
PCA rate (number of PCAs).	1.4% (5)	6.2%	10.4%	N/A

\*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

### Examples of achievement data comparisons for respiratory and Type Two Diabetes indicators

Long term conditions	Time period	Time period
Type Two Diabetes	01/04/2018 to 31/03/2019	01/04/2019 to 31/03/2020
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months.	89.8%	54.7%

The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less	90.3%	82.7%

Long term conditions	Time period	Time period
Respiratory	01/04/2018 to 31/03/2019	01/04/2019 to 31/03/2020
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months	98.6%	92.3%
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions.	72.7%	80.5%

## Families, children and young people

## Population group rating: Inadequate

### Findings

Since our previous inspection on 20 November 2019, there have been changes in the provider's achievement percentage rate for childhood immunisations. (Applicable time period for comparison: 01/04/2018 to 31/03/2019). For example:

- The practice has not met the minimum 90% for five of five childhood immunisation uptake indicators. In addition, the practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for five out of five childhood immunisation uptake indicators.
- Staff told us they contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The provider could not demonstrate how they had assessed the needs of their patient population. For example, there was limited practice nurse provision at the practice, which may have impacted on childhood immunisation achievement rates. They could not demonstrate that clinical staff had been appropriately trained and competency checked.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	70	89	78.7%	Below 80% uptake
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)	74	95	77.9%	Below 80% uptake
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)	75	95	78.9%	Below 80% uptake
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)	74	95	77.9%	Below 80% uptake
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)	83	101	82.2%	Below 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>

### Comparison of achievement indicators for childhood immunisations

Child Immunisation	Time period	Time period
	01/04/2018 to 31/03/2019	01/04/2019 to 31/03/2020
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB)	77.3%	78.7%



The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)	78.4%	77.9%
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster)	77.5%	78.9%
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)	78.4%	77.9%
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)	Not included in the previous report	82.2%

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

Population group rating: Inadequate

#### Findings

- Since our previous inspection on 20 November 2019, there has been a change in the provider's achievement percentage rate for cervical screening. At that time, the provider's achievement rate for this indicator was 63.5%. This represents a reduction of 3.5%. (Applicable time period for comparison: 01/04/2017 to 31/03/2018)
- The practice has a blood pressure monitoring assessment tool available on their website for patients to use. If a high blood pressure reading is scored, and this is a new concern, patients are advised to make an appointment with a GP as soon as possible.
- The provider could not demonstrate how they had assessed the needs of their patient population. For example, there was limited practice nurse provision at the practice, which may have impacted on cervical screening achievement rates. They could not demonstrate that clinical staff had been appropriately trained and competency checked.

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)	60.0%	N/A	80% Target	Below 70% uptake

Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	62.3%	59.3%	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)	56.1%	52.4%	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)	92.9%	92.0%	92.7%	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)	50.0%	51.6%	54.2%	No statistical variation

## People whose circumstances make them vulnerable

Population group rating: Inadequate

### Findings

- Same day appointments and longer appointments were offered when required.
- The practice had a system in place to offer an annual health check to all patients with a learning disability. Staff told us they had an action plan in place to follow up patients and invite them into the practice for a health check.
- The provider told us they participated in regular multidisciplinary meetings with other healthcare professionals to discuss patients at-risk and nearing end-of-life. However, notes from clinical meetings contained little detail, including which professionals were present. The provider did not submit evidence regarding end of life care meetings. Following the inspection, the provider submitted evidence of an appropriate meeting template which included a tracker to follow up any action points.
- The provider could not demonstrate they had identified and assessed the needs of all patients whose circumstances make them vulnerable within their patient population. They told us how they engaged with some hard to reach patient groups. For example, people with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

**Population group rating: Inadequate**

**Findings**

- The practice has a depression self-assessment tool available on their website for patients to use.
- When asked, the provider could not provide evidence to demonstrate they had identified and assessed the needs of all patients who experienced poor mental health within their patient population.
- All staff had undertaken dementia awareness training.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QoF)</small>	92.9%	85.6%	85.4%	No statistical variation
PCA* rate (number of PCAs).	22.2% (16)	7.0%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QoF)</small>	100.0%	83.0%	81.4%	Significant Variation (positive)
PCA rate (number of PCAs).	6.5% (2)	5.4%	8.0%	N/A

\*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

**Comparison of achievement data for this mental health indicator**

Mental Health Indicators	Time period	Time period
	01/04/2018 to 31/03/2019	01/04/2019 to 31/03/2020
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months	100.0%	92.9%

## Monitoring care and treatment

**There was limited monitoring of the outcomes of care and treatment.**

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	535.2	533.9
Overall QOF score (as a percentage of maximum)	95.7%	95.5%
Overall QOF PCA reporting (all domains)	7.7%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Partial
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Not assessed

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

The provider submitted evidence of two audits undertaken by the primary care network (PCN) pharmacists. One audit was one-cycle and the second was concerned with medicines optimisation. They could not demonstrate they had self-initiated and driven any quality improvement for patient care in the practice.

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Partial 1 2
The practice had a programme of learning and development.	Partial 3 4
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y 5
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial 5

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 6
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial 7
<p>1. The provider could not demonstrate specific core training for clinical staff; that they had been competency checked; or that they had clinical oversight of their work. For example, long term condition management. They submitted a clinical protocol regarding the practice nurse and healthcare assistants' (HCA) roles within the practice. However, this contained only a list of activities the practice nurse and HCAs undertake.</p> <p>2. The provider could not demonstrate the healthcare assistants' specific core training, that they had been appropriately competency checked or that they had clinical oversight of their work. For example, long term condition management. They submitted a clinical protocol regarding the healthcare assistants' role within the practice. However, this contained only a list of activities the healthcare assistants would undertake. In addition, we reviewed evidence that the provider had not assured themselves that one HCA had undertaken the Care Certificate qualification during their induction period.</p> <p>3. Following the inspection, the provider submitted evidence of clinical protocols for the practice nurse and healthcare assistants' activities regarding asthma reviews; blood pressure measurement; contraceptive pill checks; wound dressing; dementia and mental health reviews for patients; diabetic foot checks; reviews for patient with learning difficulties; urine analysis and vaccinations. However, the protocols submitted did not contain appropriate information. For example, they did not include frameworks for the management of a specific disorder or clinical situation and define areas of responsibility, references regarding evidence-based research and were unsigned by a clinician. In addition, there was no differentiation between the roles and responsibilities of a practice nurse, a trained registered healthcare professional and the healthcare assistants. Because of this we are not assured regarding patient safety.</p> <p>4. The provider could demonstrate they had made some improvements to monitor and manage training for staff. However, they could not demonstrate this was an entirely effective system.</p> <p>For example, we reviewed evidence submitted by the provider and identified gaps in training for:</p> <ul style="list-style-type: none"> <li>• Basic life support (BLS): we reviewed evidence that two out of seven clinical staff had not undertaken regular BLS training. In addition, we found that ten out of twelve non-clinical staff had not undertaken regular BLS training.</li> <li>• Information governance: we reviewed evidence that four out of eighteen staff had not undertaken regular information governance training.</li> <li>• Infection prevention and control: we reviewed evidence that two out of eighteen staff had not completed regular infection prevention and control training</li> <li>• Fire safety: We reviewed evidence that three out of twenty-two staff had not undertaken regular fire safety training.</li> <li>• Anaphylaxis: we reviewed evidence that two members of clinical staff, who may be involved in the administration of vaccines and other injectable medicines, had not completed up-to date anaphylaxis training.</li> </ul> <p>5. We reviewed six staff records and identified gaps regarding inductions for those staff members who had been newly recruited. For example, we saw that three out of six staff records did not</p>	

contain evidence of an induction programme in place. Following the inspection the provider submitted evidence of an induction pack for new employees, new Employee Recruitment, Selection, Interview & Appointment Policy & Protocol and an Induction Acknowledgment Form. We will review this at our next inspection.

6. The provider could not demonstrate that the clinical staff had undertaken appropriate regular formal clinical supervision, with evidence of minuted meetings and had undertaken regular annual appraisals. Following the inspection, the provider submitted evidence of a formal clinical supervision meeting and an assessment record with a member of staff. In addition, they re-submitted their appraisals policy, which stipulated that appraisals should be undertaken every 18 months. This had a potential impact on the provider's approach regarding managing and supporting staff when their performance was poor or variable. For example, an 18-month gap between appraisals is potentially too long a time period to raise any performance concerns with staff members.
7. The provider had not assured themselves of the competence of clinical staff involved in advanced clinical practice. For example, they submitted limited evidence for a locum advanced nurse practitioner (ANP) of additional clinical training. This was made more complex by the provider not defining the scope of the ANP's role within an appropriate clinical protocol. In addition, the provider had not submitted evidence of a clinical protocol for the clinical pharmacist who is a non-medical independent prescriber, defining the scope and remit of the role they are undertaking.

The provider told us they employed an ANP via a locum agency. They submitted a protocol regarding the activities/roles the ANP undertakes. However, this contained the information that the locum agency was responsible for providing the protocol for the ANP to work within the practice.

## Coordinating care and treatment

### Staff could not always demonstrate they work together 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.	Partial
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
<ul style="list-style-type: none"> <li>• The provider submitted evidence of clinical and practice meetings for the past 12 months. However, the minutes of the meetings lacked sufficient detail and any action points, with appropriate follow-up, to demonstrate they worked together with multi-disciplinary teams and organisations to deliver effective care and treatment. Following the inspection, the provider submitted evidence of an appropriate meeting template which included a tracker to follow up any action points.</li> </ul>	

## Helping patients to live healthier lives

### Staff were not always 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.	Partial 1
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Not assessed
Patients had access to appropriate health assessments and checks.	Partial 2
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.	Not assessed
<ol style="list-style-type: none"> <li>Staff told us that due to the Covid 19 pandemic, the identification of patients who may need extra support had been challenging. For example, the identification of carers. However, they told us they planned to address this by using the practice recall systems for long term condition reviews and the administration of influenza vaccines to improve this.</li> <li>Staff told us that health assessments and checks had been paused due to the Covid 19 pandemic. However, they told us they were beginning to see patients again, including by face to face appointments if necessary. We reviewed evidence of a telephone consultation for a patient who had been diagnosed with asthma. It was unclear how the patient's inhaler technique had been assessed by telephone consultation.</li> </ol>	

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y 1
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 2
1. We reviewed evidence that all clinical staff had undertaken mental capacity act training and that staff had documented consent within clinical records.	

2. As part of our remote clinical records searches, we reviewed a sample of two patient records in which Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions had been documented and found these decisions had been made appropriately and were in line with relevant legislation.



## Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

	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

### National GP Survey results 2021

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)	80.8%	84.9%	89.4%	Tending towards variation (negative)
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)	79.6%	82.8%	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)	90.8%	92.8%	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)	69.1%	77.0%	83.0%	Tending towards variation (negative)

## National GP Survey results comparison of achievement data for caring indicators

Indicator	Time period	Time period
	01/01/2019 to 1/03/2019	01/01/2021 to 31/03/2021
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	80.0%	80.8%
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	76.1%	79.6%
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	92.1%	90.8%
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice	64.5%	69.1%

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

### 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
<ul style="list-style-type: none"> <li>A social prescriber was available from the primary care network (PCN), who attended the practice every two weeks to support and assist patients with social issues. For example, help completing forms for housing benefit.</li> </ul>	

Source	Feedback
Interviews with patients.	Due to the Covid 19 pandemic we did not speak with patients during our inspection.

### National GP Survey results 2021

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)	86.6%	88.8%	92.9%	No statistical variation

### National GP Survey results comparison of achievement data for a caring indicator

Indicator	Time period	Time period
	01/01/2019 to 1/03/2019	01/01/2021 to 1/03/2021
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	90.9%	86.6%

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y <sub>1</sub>
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y <sub>2</sub>
Information leaflets were available in other languages and in easy read format.	Y <sub>1</sub>
Information about support groups was available on the practice website.	Y <sub>2</sub>
<p>1. Interpreter services, including for BSL, were available on request and patients were asked to book this service when making their appointment. In addition, staff at the practice spoke several languages including Urdu, Punjabi and Arabic.</p> <p>2. Information was available on the practice website regarding support groups and signposting regarding disease and social supports. This is due to infection prevention and control measures implemented by the practice in line with national guidance.</p>	

Carers	Narrative
Percentage and number of carers identified.	1.06% (77 carers)
How the practice supported carers (including young carers).	We reviewed evidence that seven out of nineteen staff had undertaken carer's awareness training.
How the practice supported recently bereaved patients.	Staff told us GPs will telephone patients who have been bereaved and offer refer patients to counselling services if appropriate.

## Privacy and dignity

### The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
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: requires improvement

At our previous inspection on 20 November 2019 we rated the provider as requires improvement for providing responsive services because we found concerns regarding:

- The provider could not demonstrate that they had sufficiently acted on and reviewed any changes made in relation to low patient satisfaction scores with access to services.

At this inspection on 26 and 31 August 2021 we rated the provider as requires improvement for providing responsive services because we found concerns regarding:

- Overall, the GP Patient Survey achievement rates, regarding providing responsive services, demonstrated improvement. However, several scores remained as tending towards negative variation.
- The provider had not undertaken a joint needs assessment regarding the needs of the patient population groups or had otherwise considered what services were required to support and address the needs of the patients in the practice.

These areas affected all population groups, so we rated all population groups as requires improvement for providing responsive services.

### Responding to and meeting people's needs

#### Services did not meet always patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Partial
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
<ul style="list-style-type: none"><li>• The provider could not demonstrate they had undertaken a joint needs assessment regarding the needs of the patient population groups or had otherwise considered what services were required to support and address the needs of the patients in the practice.</li></ul>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am-6.30pm
Tuesday	8am-6.30pm
Wednesday	8am-6.30pm
Thursday	8am-6.30pm
Friday	8am-6.30pm
Appointments available:	
Monday	9am-6pm
Tuesday	9am-6pm
Wednesday	9am-6pm
Thursday	9am-6pm
Friday	9am-6pm

## Older people

**Population group rating: Requires improvement**

Findings
<ul style="list-style-type: none"> <li>• The practice offered prioritised home visits for those with enhanced needs and complex medical issues.</li> <li>• We saw that double appointments were available to meet patient needs, on request, or where necessary.</li> <li>• The provider referred patients to a rapid response service when required.</li> <li>• A domiciliary phlebotomy service was available for housebound patients.</li> <li>• Patients were referred to dementia clinics and memory testing.</li> <li>• The provider told us they offered home visits in the evening.</li> <li>• An e-consult triage system was in place and appointments were offered to patients with a GP via telephone or on a face to face basis, when necessary, between 9am-6pm, Monday to Friday.</li> <li>• We saw that pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation and weekday evening and weekend appointments were available.</li> </ul>

## People with long-term conditions

Population group rating: Requires improvement

### Findings

- The provider referred patients to a rapid response service when required.
- The provider recalled patients for reviews of long term conditions.
- We saw that double appointments were available to meet patient needs on request or where necessary.
- An e-consult triage system was in place and appointments were offered to patients with a GP via telephone or on a face to face basis, when necessary, between 9am-6pm, Monday to Friday.
- We saw that pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation and weekday evening and weekend appointments were available.

## Families, children and young people

Population group rating: Requires improvement

### Findings

- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- An e-consult triage system was in place and appointments were offered to patients with a GP via telephone or on a face to face basis, when necessary, between 9am-6pm, Monday to Friday.
- We saw that pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation and weekday evening and weekend appointments were available.
- A room to accommodate breast-feeding was available on request.

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

Population group rating: Requires improvement

### Findings

- An e-consult triage system was in place and appointments were offered to patients with a GP via telephone or on a face to face basis, when necessary, between 9am-6pm, Monday to Friday.
- We saw that pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation and weekday evening and weekend appointments were available.

**People whose circumstances make them vulnerable**

**Population group rating: Requires improvement**

**Findings**

- An e-consult triage system was in place and appointments were offered to patients with a GP via telephone or on a face to face basis, when necessary, between 9am-6pm, Monday to Friday.
- We saw that pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation and weekday evening and weekend appointments were available.
- We saw that double appointments were available to meet patient needs on request or where necessary.
- BSL and interpreter services were available on request, to meet accessible standards.
- Automated front doors provided accessibility for wheelchair users.

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

**Population group rating: Requires improvement**

**Findings**

- An e-consult triage system was in place and appointments were offered to patients with a GP via telephone or on a face to face basis, when necessary, between 9am-6pm, Monday to Friday.
- We saw that pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation and weekday evening and weekend appointments were available.
- We saw that double appointments were available to meet patient needs on request or where necessary.
- The provider sent out reminders, by text message, to patients regarding appointments and test results.



## Access to the service

**People reported they were not always able to access care and treatment in a timely way.**

National GP Survey results

	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.	Partial
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
We reviewed data from the National GP Patient Survey and saw that improvements had been made by the provider, since our previous inspection on 20 November 2019. However, these indicators remained tending towards a negative variation. Please see information below.	

## GP Patient Survey 2021

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)	40.0%	N/A	67.6%	Significant Variation (negative)
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)	52.7%	65.7%	70.6%	Tending towards variation (negative)
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)	50.3%	64.3%	67.0%	Tending towards variation (negative)
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)	68.9%	76.3%	81.7%	Tending towards variation (negative)

## GP Patient Survey comparison of responsive indicators

Indicator	Time period 01/01/2019 to 31/03/2019	Time period 01/01/2021 to 31/03/2021
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	24.0%	40.0%
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment	40.6%	52.7%
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times	49.2%	50.3%
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered	50.3%	68.9%

Source	Feedback
Google reviews	<p>We reviewed information for 51 patients who had submitted reviews for the practice within the past 12 months. This may be evaluated thus:</p> <p>There were:</p> <ul style="list-style-type: none"> <li>• 27 one-star reviews.</li> <li>• 5 four-star reviews</li> <li>• 19 five-star reviews.</li> </ul> <p>On average this amounted to an overall score of 2.8 stars for The Forest Surgery.</p>

## 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.	9
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3

Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0
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	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

## Well-led

## Rating: Inadequate

**At our previous inspection on 20 November 2019 we rated the provider as requires improvement for providing well-led services because we found concerns regarding:**

- The provider was unable to demonstrate that learning from significant events and patient safety alerts was effectively shared.
- Monitoring risk assessments.
- Insufficient attention paid to patient satisfaction with services.
- A lack of oversight of the training required for some lead roles in practice safety.

**At this inspection on 26 and 31 August 2021, we found the provider had made improvements regarding:**

- Implementing a system for sharing learning from significant events and patient safety alerts.
- Increased patient satisfaction achievement rates in the national GP Patient survey, although some these indicators tended towards a negative variation.
- The identification of staff who undertook lead roles regarding patient safety.

**At this inspection on 26 and 31 August 2021, we found concerns regarding:**

- Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.
- We were not assured that comprehensive and effective systems and process were in place and regularly reviewed to manage risk and some performance data.
- The provider was aware that a proportion of their quality and outcomes framework (QOF) and Public Health England (PHE) relating to childhood immunisation and cervical screening achievement rates were poor. However, systematic processes were not effective in improving and managing patient outcomes on an ongoing basis.
- The provider had some systems in place to identify, manage and mitigate risks, however these were not always effective.

- We found that structures, processes and systems to support good governance were not effective. In particular, we found concerns around the management and monitoring of safeguarding, recruitment, premises risk assessments, urgent two-week wait referrals, cervical screening.

The provider could not demonstrate who had oversight of all systems and processes to ensure effective care and to drive quality improvement.

- The provider could not demonstrate they had a clear vision, set of values or a mission statement in place.

The management team could not demonstrate they were aware of the challenges to delivering care within a primary care setting or that they had an action plan to address those challenges.

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

## Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N 1
They had identified the actions necessary to address these challenges.	N 2 3
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N 4
<ol style="list-style-type: none"> <li>1. The management team could not demonstrate they had a comprehensive oversight of all the challenges to delivering care within a primary care setting or that they had an effective action plan to address those challenges.</li> <li>2. Leaders could not demonstrate the capacity to prioritise safety and quality improvement. Several systems and processes had been found to be unsafe. For example, the management of high-risk medicines; two week wait urgent referrals; historical patient safety alerts that remain clinically relevant and premises risk assessments.</li> <li>3. We found the practice was reactive rather than proactive and some actions had been undertaken immediately following the inspection. For example, failsafe processes had been created for two week wait urgent referrals and cervical screening following our written headline inspection feedback to the provider.</li> <li>4. The provider submitted evidence of a business plan in which they stated, as per their core objectives, they will be planning towards succession plan for retirement closer to the appropriate time.</li> </ol>	

## Vision and strategy

**The practice had a clear vision, but it was not supported by a credible strategy to provide high quality sustainable care.**

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Partial 1
There was a realistic strategy to achieve their priorities.	N 2
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N 3
Staff knew and understood the vision, values and strategy and their role in achieving them.	N 3
Progress against delivery of the strategy was monitored.	Partial 4
<ol style="list-style-type: none"> <li>1. The provider could demonstrate they had a mission statement, vision and set of values in place. However, we found patient achievement data was poor in some clinical areas and governance arrangement did not contain fail-safe systems. We were not assured regarding patient safety.</li> </ol>	

2. The provider could not demonstrate they had a credible strategy in place to address any challenges they had identified and concerns we found on inspection. We found that there was a lack of oversight in key areas relating to the safety systems in place, staff provision, and governance structures all of which had the ability to compromise the quality of care provided by the practice and impact on its vision, aims and objectives.
3. We were not assured that staff knew and understood the vision, values and strategy and their role in achieving them. It was not possible to determine if staff we spoke with were aware of the practice vision and values. They referred any questions we asked of them to the lead GP and practice manager.
4. Although the provider could demonstrate they had a vision and set of values, they could not assure us they monitored progress of any strategy to drive improvements.

## Culture

### The practice culture did not effectively support 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.	N <sup>1</sup>
There was a strong emphasis on the safety and well-being of staff.	Partial <sup>2</sup>
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Not assessed
The practice had access to a Freedom to Speak Up Guardian.	Not assessed
Staff had undertaken equality and diversity training.	Y <sup>3</sup>
<ol style="list-style-type: none"> <li>1. The provider had a policy in place regarding the duty of candour. However, it was not possible to determine if staff we spoke with felt able to raise concerns. They referred any questions we asked of them to the lead GP and practice manager.</li> <li>2. The provider could demonstrate they had considered and acted to facilitate safety. For example, undertaking Covid 19 risk assessments for relevant staff. However, they could not otherwise demonstrate how they promoted and supported staff well-being.</li> <li>3. We reviewed evidence that all staff had undertaken equality and diversity training.</li> </ol>	

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

Source	Feedback
Staff	Staff we spoke to had worked at the practice for several years. They stated they felt supported and could ask for help if needed.

## Governance arrangements

### The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial 1 2
Staff were clear about their roles and responsibilities.	Partial 3
There were appropriate governance arrangements with third parties.	Partial 4
<p>1. We found that structures, processes and systems to support good governance were not effective. In particular, we found concerns around the management and monitoring of safeguarding, recruitment, premises risk assessments, urgent two-week wait referrals and cervical screening.</p> <p>2. The provider submitted evidence that practice policies had been reviewed within the previous 12 months. However, that all practice policies had not been updated as required. For example, the safeguarding policy did not contain recent intercollegiate guidance and changes to levels of safeguarding training policy regarding different staff groups.</p> <p>3. Although all staff had specific roles and responsibilities the practice could not demonstrate who had oversight of all systems and processes to ensure effective care and to drive quality improvement. For example, effective staffing in relation to core and role-specific training, supervision and appraisal, clinical audit and an overall lack of oversight to ensure safe and effective care. Following the inspection, the provider submitted evidence of a formal clinical supervision meeting and an assessment record with a member of staff. In addition, they re-submitted their appraisals policy, which stipulated that appraisals should be undertaken every 18 months.</p> <p>4. The provider could not demonstrate what governance arrangements they had in place regarding safety and the practice premises. For example, premises risk assessments for back-up generators they had in the practice.</p>	

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial 1
There were processes to manage performance.	Partial 2
There was a quality improvement programme in place.	Partial 3

There were effective arrangements for identifying, managing and mitigating risks.	Partial 4
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.	
<p>1. We were not assured that comprehensive and effective systems and process had been identified, were in place and regularly reviewed to manage risk and some performance data. For example, during our inspection we found the provider had not undertaken regular audits to assure themselves that all patients who had been referred via the two-week wait urgent referral pathway had been followed up. In addition, they had not undertaken regular audits to assure themselves that results had been obtained for female patients who had undertaken cervical screening. We found the provider did not have complete oversight of safeguarding systems. Therefore, they could not demonstrate patients were safely reviewed. The provider could not demonstrate that it proactively identified and responded to all risks and assessed the impact on safety and quality.</p> <p>2. The provider was a single-handed GP who was supported by locum/sessional GPs. There was limited practice nurse provision at the practice. The provider could not demonstrate they had self-evaluated poor or variable performance data and implemented action plans to drive improvement. For example, the lack of self-initiated clinical audits in place to drive improvement in patient outcomes and the lack of improvement in achievement rates for cervical screening and childhood immunisation rates since our last inspection.</p> <p>3. The provider had some systems in place to identify, manage and mitigate risks, however these were not always effective. For example, the systems to monitor and manage patient safety alerts and high-risk medicines and the two-week wait urgent referral and cervical screening safety netting systems.</p> <p>4. The provider could not demonstrate they had considered the impact on quality and sustainability when service developments or changes had occurred. For example, the impact on childhood immunisations and cervical screening when there is limited practice nurse provision.</p>	

### **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.	N 1
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
The provider could not demonstrate they had a safe, effective system in place to manage backlogs of activity for patients whose treatment had been delayed. For example, two-week wait urgent referrals.	

### Appropriate and accurate information

#### The practice was reactive and not pro-active regarding acting on appropriate and accurate information.

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial 1
Performance information was used to hold staff and management to account.	Partial 2
There were effective arrangements for identifying, managing and mitigating risks.	Partial 3 4
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<ol style="list-style-type: none"> <li>1. The practice was aware a proportion of their quality and outcomes framework (QOF) and Public Health England (PHE) achievement rates were poor. However, there were no effective systematic processes to improve and manage patient outcomes on an ongoing basis through a structured recall system. In particular, patients who have been diagnosed with Type Two Diabetes; cervical screening and childhood immunisations.</li> <li>2. The provider could not demonstrate that clinical staff has been appropriately trained, competency checked and had undertaken formal clinical supervision. Practice nurse appointments were limited. These factors may have impacted on patient achievement data indicators.</li> <li>3. We could not be assured that information held by the provider was accurate, valid, reliable and timely as we had found gaps in their systems. For example, the provider could not demonstrate they had assured themselves that all patients who had been prescribed high-risk medicines and medicines that required additional monitoring had been followed up. They could not demonstrate they had undertaken regular audits of those medicines and historical patient safety alerts, that remained clinically relevant, to evidence this. We are not assured of patient safety.</li> <li>4. The provider could not demonstrate there were effective arrangements for identifying, managing and mitigating risks. For example, the management of two-week wait urgent referrals and cervical screening. Following the inspection, the provider submitted evidence that they had implemented failsafe processes.</li> </ol>	

## 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.	N/A
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.	N/A
The practice advised patients on how to protect their online information.	N/A

## Engagement with patients, the public, staff and external partners

**There was limited involvement of the public, staff and external partners to promote and 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.	N <sup>1</sup>
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Partial <sup>2 3</sup>
<ol style="list-style-type: none"> <li>1. The provider could not demonstrate that staff views had been reflected in planning and delivering services for patients.</li> <li>2. The provider had identified a challenge to delivering good quality care, for example, recruiting appropriate clinical staff to help deliver patient care and treatment. However, they could not demonstrate they had worked collaboratively with key stakeholders to analyse the needs of the patient population group and developed an action plan to address any challenges they had identified.</li> <li>3. The provider was part of the Forest 8 Primary Care Network (PCN) with several other local practices and a clinical pharmacist from the PCN attended the practice every two weeks to support them with medicines management. They were aware of challenges with clinical staffing and were seeking to address them. However, they could not otherwise demonstrate how they had assessed the needs of the population.</li> </ol>	

## Feedback from Patient Participation Group.

### Feedback

We spoke with a member of the Patient Participation Group (PPG) by telephone due to our Covid 19 infection prevention control restrictions, in line with national guidance, to mitigate the infection transmission risk. They told us they feel the practice offers an excellent service and they are treated with dignity, compassion and respect 'without a shadow of a doubt'.

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial 1
Learning was shared effectively and used to make improvements.	Partial 2
<ol style="list-style-type: none"> <li>1. We were not assured that systems and process for learning and continuous improvement were developed and implemented. For example, regular auditing of their two-week wait urgent referral and cervical screening safety netting systems and management of high-risk medicines.</li> <li>2. The provider could not demonstrate that learning was always used to make improvements. For example, the provider had recorded only one significant event they had shared these with the national reporting and learning system (NRLS) in the previous 12 months. In addition, we reviewed information that some significant events had not been recorded and any learning from this had potentially been lost.</li> </ol>	

### 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$

Significant variation (negative)

≥3

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

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

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

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

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

#### Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease.
- **PHE**: Public Health England.
- **QOF**: Quality and Outcomes Framework.
- **STAR-PU**: Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- **\*PCA**: Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#) ). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
- 
- ‰ = per thousand.