

Care Quality Commission

Inspection Evidence Table

Dr Sangeeta Rathor (1-511237925)

Inspection date: 03 December 2018

Date of data download: 16 January 2019

At the last inspection in June 2016 we rated the practice as Good Overall. At this inspection, we found concerns relating to the practice. We rated the practice as requires improvement because:

The practice recorded and analysed significant events. However, the system of identifying, learning, sharing and making improvements following Significant Events Analyses (SEA) was not effective.

Safeguarding systems and policies were not being followed.

The practice could not evidence how they ensured some clinical staff were up to date with current guidance and how they were supported to perform their role to ensure they had competencies to do so. Safely.

Staff appraisals had not been completed in a timely manner.

Results from the national GP patient survey showed patients were not happy with access to appointments. The practice was aware of this and only acted following our inspection feedback.

There was a lack of good governance and leadership at the practice.

Overall rating: Inadequate

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Safe Rating: Requires Improvement

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse. However, they were not followed.

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
There were policies covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	Y

Safeguarding	Y/N/Partial
Policies and procedures were monitored, reviewed and updated.	Y
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Y
There was active and appropriate engagement in local safeguarding processes.	Partial
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Safeguarding systems, processes and practices had been developed, implemented and communicated to staff. However, during the inspection we found evidence of an incident relating to a patient where the practice had failed to follow their safeguarding procedure and make a referral to the safeguarding team. We saw this was done after a further appointment.</p> <p>We saw some evidence of electronic pop up alerts for children in need, on child protection registers at a sample of patient records looked at.</p> <p>All staff received up-to-date safeguarding and safety training appropriate to their role. Staff were able to talk us through the steps they would follow, if they had safeguarding concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	N
Staff had any necessary medical indemnity insurance.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There were no systems to ensure the registration of clinical staff (including nurses) was checked and regularly monitored. However, we checked that all clinicians were registered with the specific bodies</p>	

during the inspection.

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test:	Y 21/04/18
There was a record of equipment calibration. Date of last calibration:	Y 21/04/18
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check:	Y 30/04/18
There was a log of fire drills. Date of last drill:	Y 30/04/18
There was a record of fire alarm checks. Date of last check:	Y 30/10/18
There was a record of fire training for staff. Date of last training:	Y May 2018
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion:	Y 30/10/18
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: All checks were carried out by NHS property services. The practice was provided with records of all checks by the NHS property services.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	Y 30/10/18
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Y 30/10/18
Explanation of any answers and additional evidence: All checks were carried out by NHS property services under contract to the provider.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Date of last infection prevention and control audit: 22/11/2018	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: All recommendations from the infection control audit had been completed. For example, the practice ordered sharps bins for the disposal of cytotoxic medicinal products after an audit. The cleaning of the premises of the practice was the responsibility of NHS property services. The practice had access to these records.	

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.	N
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
Explanation of any answers and additional evidence: The practice had approximately 6000 patients for the combined patient list. The GP sessions available were 10 sessions. The practice were not able to demonstrate they offered sufficient cover for patients	

including during busy periods.

The principal GP told us they had not planned for their sickness or absence as they hardly went off sick. There was also no system in place that could clearly demonstrate that when there were changes to services or staff the practice assessed and monitored the impact on safety other than ensuring staff covered each other for sickness, leave or absence.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation. However, these were not always followed.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) NHS Business Service Authority - NHSBSA)	1.11	0.78	0.94	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2017 to 30/09/2018) (NHSBSA)	4.7%	10.2%	8.7%	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A

Medicines management	Y/N/Partial
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p data-bbox="57 779 810 817">Explanation of any answers and additional evidence:</p> <p data-bbox="57 862 1501 1048">The practice had a process where the nurse reviewed patients with minor ailments and sent a prescription to the GPs for authorisation. We saw no evidence that the nurse was provided with appropriate guidance and supervision during this process as they were not a qualified prescriber. The GP explained that that they always verified the prescriptions prior to authorising them. However, they could not evidence the system they followed.</p> <p data-bbox="57 1099 1509 1285">Though the practice had a policy for managing prescriptions, this was not being followed. We found several prescriptions in the reception awaiting collection. Some of these had been waiting to be collected for over six months. Prescriptions seen included those for a patient with Dementia. The GP and the practice manager were not aware that the process of following up uncollected prescriptions was not being followed up as per the practices policies.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong. However not all incidents had been followed up.

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.	Partial
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	5
Number of events that required action:	5
Explanation of any answers and additional evidence: The practice recorded and analysed significant events and staff were able to raise awareness of what was considered a significant event. However, the system of learning, sharing and making improvements following Significant Events Analyses (SEA) required improvement. From the records we reviewed, we saw an incident that had occurred regarding a safeguarding referral that had not been progressed further by staff. We saw that the practice took appropriate action later when the patient in question re-presented. This incident had not been recorded as a significant event to allow learning and to avoid re- occurrence. We saw no discussion of this event in any clinical meeting minutes.	

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

Event	Specific action taken
Computer misuse of internet for personal use.	A fortnightly check was put in place and a verbal warning was given. All staff were given an update on the practices policy relating to the use of information technology.
Reception area left unmanned. The practice manager went down to drop off some letters at reception and found no staff at the desk.	Advised all reception team they need to arrange cover before taking a comfort break.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: There was a system for disseminating safety alerts to relevant staff and we saw evidence that the practice acted to identify and notify patients affected by alerts.	

Effective**Rating: Requires Improvement****Effective needs assessment, care and treatment**

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways were in place to make sure that patients' needs were addressed.	Partial
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
<p>Explanation of any answers and additional evidence:</p> <p>GPs were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.</p> <p>However, we could not evidence how the practice ensured the nurse was kept up to date with current guidance.</p>	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) (NHSBSA)	0.73	0.55	0.81	No statistical variation

Older people**Population group rating: requires improvement**

Findings
<p>The practice is rated as requires improvement for the care of older people. The provider was rated as inadequate for well-led services; and requires improvement for safe, effective, caring and responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.</p> <p>The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.</p> <p>The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.</p>

Health checks were offered to patients over 75 years of age.

People with long-term conditions- requires improvement

Findings

The practice is rated as requires improvement for the care of people with long term conditions. The provider was rated as inadequate for providing well-led services and requires improvement for providing safe, effective, caring and responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

GPs who were responsible for reviews of patients with long term conditions had received specific training.

GPs told us they offered reviews opportunistically if patients had failed to attend a previous appointment. Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met.

The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. However, data showed the practice had a high exception reporting for COPD. The practice were aware of this and this was yet to be addressed.

Adults with newly diagnosed cardio-vascular disease were offered statins.

People with suspected hypertension were offered ambulatory blood pressure monitoring.

Patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.

The practice followed up on patients with long-term conditions discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

The practice could demonstrate how it identified patients with commonly undiagnosed conditions, for example, diabetes, chronic obstructive pulmonary disease, atrial fibrillation and hypertension.

The practice's performance on quality indicators for long term conditions was in line with local and national averages.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	75.9%	77.9%	78.8%	No statistical variation
Exception rate (number of exceptions).	14.0% (23)	10.4%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12	85.8%	77.3%	77.7%	No statistical variation

months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	5.5% (9)	7.5%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	80.7%	77.9%	80.1%	No statistical variation
Exception rate (number of exceptions).	14.6% (24)	8.1%	13.5%	N/A

Other 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, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	95.2%	78.0%	76.0%	Significant Variation (positive)
Exception rate (number of exceptions).	3.1% (4)	2.6%	7.7%	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 (01/04/2017 to 31/03/2018) (QOF)	95.8%	91.7%	89.7%	No statistical variation
Exception rate (number of exceptions).	29.4% (10)	8.9%	11.5%	N/A
The practice told us they were aware of the high exception reporting for COPD. However, this was yet to be addressed.				

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	86.6%	82.9%	82.6%	No statistical variation
Exception rate (number of exceptions).	5.9% (21)	3.6%	4.2%	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 (01/04/2017 to 31/03/2018) (QOF)	94.4%	96.3%	90.0%	No statistical variation
Exception rate (number of exceptions).	0 (0)	10.7%	6.7%	N/A

Families, children and young people requires improvement

Findings

The practice is rated as requires improvement for the care of families, children and young people. The practice was rated as inadequate for well-led services; and requires improvement for safe, effective, caring and responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Childhood immunisation uptake rates were all below the World Health Organisation (WHO) targets. The practice were aware their uptake rates for childhood immunisations were below the target rate and had been working to improve uptake rates by offering appointments out of school hours and identifying gaps in immunisation history for newly registered children. They also explained to us that this was a reporting issue relating to the separate concerns and most of the data not being correctly recorded due to different codes of the practices. We were not able to apply the invalidated data for the two practices to confirm that improvements had been made.

The practice had arrangements to identify and review the treatment of newly pregnant women on long acting medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.

The practice had arrangements for following up failed attendance of children's appointments following appointment in secondary care or for immunisation and would liaise with health visitors when necessary.

Young people could access services for sexual health and contraception.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib) ((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	-999	-999	50.0%	Below 80% (Significant variation negative)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	5	9	55.6%	Below 80% (Significant variation negative)
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) (01/04/2017 to 31/03/2018) (NHS England)	5	9	55.6%	Below 80% (Significant variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	5	9	55.6%	Below 80% (Significant variation negative)

Any additional evidence or comments

Due to the two separate commissioning contracts at the practice. We were unable to confirm the accuracy of the immunisation figures and no other reports relating to data were available during the inspection.

Working age people (including those recently retired and students) requires improvement

Findings

The practice is rated as requires improvement for the care of working age people including those recently retired and students. The provider was rated as inadequate for well-led services; and requires improvement for safe, effective, caring and responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	64.0%	63.7%	71.7%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	73.3%	66.1%	70.0%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	44.8%	45.8%	54.5%	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. (01/04/2017 to 31/03/2018) (PHE)	33.3%	67.2%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	22.2%	53.0%	51.9%	No statistical variation

Any additional evidence or comments

The practice's uptake for cervical screening was 64%, which was below the 71% coverage target for the national screening programme but in line with the CCG average. We were told the patient demographic (where there was a wide ethnic mix) were difficult to engage and had contributed to low uptake rates. The practice was aware of their performance and were continually reviewing their processes to engage these patients and improve uptake. For example, ensuring they had access to a female sample taker and reviewing the recall system. Although there was no evidence these improvements were having an impact.

The practice's uptake for breast cancer screening was comparable to the national average.

The practice's uptake for bowel cancer screening was below the national average. The practice proactively contacted patients who failed to return the initial bowel cancer screening kit, offered patients opportunistic screening during consultations, and displayed health promotion material in the waiting area.

People whose circumstances make them vulnerable

Population group rating: requires improvement

Findings

The practice is rated as requires improvement for the care of people whose circumstances make them vulnerable. The provider was rated as inadequate for well-led services; and requires improvement for safe, effective, caring and responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

The practice demonstrated that they had a system to identify people who misused substances.

The practice reviewed young patients at local residential homes.

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

**Population group rating: requires
improvement**

Findings

The practice is rated as requires improvement for the care of people experiencing poor mental health. The provider was rated as inadequate for well-led services; and requires improvement for safe, effective, caring and responsive services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.

When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.

Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.

All staff had received dementia training in the last 12 months.

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 (01/04/2017 to 31/03/2018) (QOF)	100.0%	90.9%	89.5%	Variation (positive)
Exception rate (number of exceptions).	0 (0)	8.0%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	100.0%	93.3%	90.0%	Variation (positive)
Exception rate (number of exceptions).	0 (0)	6.4%	10.5%	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 (01/04/2017 to 31/03/2018) (QOF)	100.0%	87.4%	83.0%	Significant Variation (positive)
Exception rate (number of exceptions).	4.3% (1)	6.4%	6.6%	N/A

Any additional evidence or comments

The practice's performance on quality indicators for mental health was above local and national averages. The practice had 36 patients with Dementia.

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	554.6	545.6	537.5
Overall QOF exception reporting (all domains)	11.1%	6.4%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements. At the time of the inspection the most recent published QOF results (2016/17) were 99% of the total number of points available which was in line with the clinical commissioning group (CCG) and national averages.	Y

Overall exception reporting was 11% (CCG average 6%; national 6%). (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate). The practice was aware of the high exception reporting and attributed this to the contractual and coding issue at the practice. The principal GP advised that this issue would be resolved when the practices contracts are changed.	
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Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

Audits had been undertaken in the following areas: urinary infections, reducing medicines related harm, smear audits, vitamin d use and medicines safety.
These activities had resulted in changes to diagnostic screening, medicines and clinical management of patients, in line with guidance.

Effective staffing

The practice was unable to demonstrate that all 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. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Partial
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	N
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:	
The practice could not evidence how they provided staff with ongoing support. All staff including the practice manager and the nurse had not received regular annual appraisals. The practice explained that this was due to the previous manager leaving the post and not handing over records kept at the practice. We saw that the nurse was not being provided with support and monitoring to ensure they	

were able to safely carry out the work delegated to them.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's telephone service there were clear and effective processes to make referrals to other services.	Y

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
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, tackling obesity.	Y

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	100.0%	95.9%	95.1%	Significant Variation (positive)
Exception rate (number of exceptions).	2.1% (10)	0.9%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y

Caring

Rating: Requires Improvement

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence:	

CQC comments cards	
Total comments cards received.	40
Number of CQC comments received which were positive about the service.	10
Number of comments cards received which were mixed about the service.	15
Number of CQC comments received which were negative about the service.	15

Source	Feedback
Comment Cards	Patients we spoke to said they felt all staff were caring, friendly and helpful. They described examples where they were listened to and treated with respect, dignity and kindness. One card provided mixed feedback, with the negative element relating to the behaviour of reception staff previously employed at the practice.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
1823	356	92	25.8%	5.05%

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 (01/01/2018 to 31/03/2018)	64.3%	85.0%	89.0%	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 (01/01/2018 to 31/03/2018)	71.9%	82.3%	87.4%	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 (01/01/2018 to 31/03/2018)	73.1%	93.3%	95.6%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	68.0%	79.5%	83.8%	No statistical variation

Any additional evidence or comments
The practice had an action plan in place to make improvements. However, at the time of our inspection they had not fully initiated the process to make improvements and they could not evidence the involvement of the Patient Participation Group in these changes.

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

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
Source	Feedback
Comments cards	Patients were positive about the involvement they had in their care and treatment. They said the GPs explained their condition and treatment and they were involved in decisions about their treatment.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	84.2%	89.9%	93.5%	No statistical variation

Any additional evidence or comments
N/A

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence:	

Carers	Narrative
Percentage and number of carers identified.	15 carers identified (1% of practice population).
How the practice supported carers.	Carers were supported and offered health checks, influenza vaccinations, and referral to support agencies. Staff signposted patients to local events for carers hosted by the CCG. Further sources of support and information were available in the waiting area.
How the practice supported recently bereaved patients.	The GPs would contact the relatives or offer a bereavement visit to the family. Flexible appointments were available on request and the practice signposted patients to support services

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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. However, patients expressed concerns with accessing appointments at the practice.

	Y/N/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
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y
Practice Opening Times	
Day	Time
Opening times:	
Monday	08:00 – 19:30
Tuesday	08:00 – 18:30
Wednesday	08:00 – 19:30
Thursday	08:00 – 19:30
Friday	08:00 – 18:30

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
1823	356	92	25.8%	5.05%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	84.4%	92.8%	94.8%	No statistical variation

Any additional evidence or comments

Older people

Population group rating: requires improvement

Findings

- All patients had a named GP who supported them in whatever setting they lived. However due to lack of adequate GP clinical sessions it was not clear that these patients were followed appropriately.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- There was a medicines delivery service for housebound patients.

People with long-term conditions

Population group rating: requires improvement

Findings

- Patients with multiple conditions had their needs reviewed in one appointment. However, we found concerns relating to the supervision and monitoring of some clinical staff providing care to this patient group.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: requires improvement

Findings

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Parents with concerns regarding children under the age of 10 could attend a drop-in clinic held at the same time as the twice weekly baby clinic.

Working age people (including those recently retired and students)

Population group rating: requires improvement

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. However, there were concerns around access to GP appointments.

People whose circumstances make them vulnerable

Population group rating: requires improvement

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. However, there were concerns around access to GP appointments.

People experiencing poor mental health (including people with dementia)

Population group rating: requires improvement

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health. However due to concerns regarding GP appointments at the practice it was not clear if these patients were attended to as required.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y

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 (01/01/2018 to 31/03/2018)	50.2%	N/A	70.3%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	57.4%	65.6%	68.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	56.6%	63.0%	65.9%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	55.8%	69.0%	74.4%	No statistical variation

Any additional evidence or comments

The practice had noted the concerns relating to access and had introduced three telephone lines to make improvements. However, they had not undertaken a review of the system to check its effectiveness. Patients feedback from the comments cards received included a lack of appointments as a common theme.

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.	Four
Number of complaints we examined.	Four
Number of complaints we examined that were satisfactorily handled in a timely way.	Three
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	N/A

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

Example(s) of learning from complaints.

Complaint	Specific action taken
Delay in service and referral to secondary care	The practice ensured that all patients are made aware of the referral process as the delay was due to secondary care.

Well-led

Rating: Inadequate

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the time of our inspection, the principal GP explained that the practice was undergoing a period of difficulty and therefore, they had not been able to provide sufficient leadership at the practice. The principal GP reported seeking help and guidance from the Royal College of General Practitioners (RCGP). However, we could not establish the support that was given by the RCGP or the impact it had on improving the leadership at the practice.</p> <p>During this inspection, we found concerns relating to the lack of GP time. The principal GP told us they were aware of access issues at the practice; however, they had not taken any action. They were aware of the need for more GP hours, but were not able to recruit any other staff due to contractual and other issues going on at the time. Following the inspection, the practice wrote to us stating that the salaried GP had agreed to increase their hours to suit the practice demands to four sessions per week.</p> <p>The practice did not have a formal succession plan. The principal GP explained that due to matters beyond their control the CCG had placed a hold on any further recruitment for a further salaried GPs or getting another GP partner on board while the contracts were being reviewed. The GP could not explain how they would cover any sickness or absence explaining that they had never taken time off sick.</p> <p>It was clear during the inspection that due to added pressure the practice leader lacked clinical oversight. For example, the principal GP told us they had not been offering clinical oversight to a clinical staff member and therefore they had been undertaking working that required close supervision and further training without being monitored.</p> <p>The practice had not assessed the risk of not having sufficient GPs at the practice to ensure they provided adequate patient access and care. Following our inspection, the principal GP contacted us to confirm that they had increased the salaried GPs working sessions to ensure the practice had sufficient clinical cover.</p>	

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.	N
There was a realistic strategy to achieve their priorities.	N
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	N
<p>Though the practice had a vision to deliver high quality care and promote good outcomes for patients. No strategy and business plans were in place to reflect the values of the practice and how these were monitored.</p> <p>Staff we spoke with shared the practices vision, however the practice could not evidence further how staffs contribution to the vision was monitored.</p>	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	N
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Partial
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
<p>The concerns raised on the day of the inspection could not evidence a culture of high-quality sustainable care. However, staff stated they felt respected, supported and valued.</p> <p>We saw no evidence of how the practice focused on the needs of patients.</p> <p>The provider was aware of the requirements of the duty of candour. However, we could not evidence how they were responding to this.</p> <p>There were no processes for providing all staff with the development they required. All staff had not received regular annual appraisals in the last year. We saw no responsibility by the principal GP in supporting the nurse to meet the requirements of professional revalidation.</p>	

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

Source	Feedback
Staff	Staff we spoke with, reported being supported to deliver their roles.

Governance arrangements

The overall governance arrangements required improvements

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	N
<p>We found concerns with the governance of the practice. The practice did not have clear governance arrangements in place. The practice held no clinical governance meetings, and the systems of recording , learning, sharing and making improvements following Significant Events Analyses (SEA) and complaints were not effective.</p> <p>Though the practice had policies, these were not being followed. We found a number of uncollected prescriptions, some which were over six months old. The practice recorded and analysed significant events. However, the system of learning, sharing and making improvements following Significant Events Analyses(SEA) was not effective. From the records we reviewed, we saw an incident that had occurred regarding a safeguarding referral that had not been progressed further by staff. This incident had not been recorded as a significant event to allow learning and to avoid re-occurrence.</p> <p>Some clinical and non-clinical staff had not received an annual appraisal.</p> <p>The practice could not demonstrate how they ensured that relevant clinical staff were supervised and had the appropriate competencies to undertake the work they had been assigned to carry out.</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.	N
There were processes to manage performance.	N
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
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.	N
Explanation of any answers and additional evidence:	
There was an ineffective, process to identify, understand, monitor and address current and future risks including risks to patient safety.	
The practice could not evidence the processes in place to manage current and future performance.	
Practice leader could not evidence they had oversight of incidents, and complaints.	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	N
Performance information was used to hold staff and management to account.	N
Our inspection indicated that information was accurate, valid, reliable and timely.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
Staff whose responsibilities included making statutory notifications understood what this entails.	N
Explanation of any answers and additional evidence:	
Staff had not been subject to a regular annual appraisal.	
The practice did not always have appropriate and accurate information. The practice had two separate contracts and yet used one reporting system.	
We could not evidence a process or system in place to identify, understand, monitor and address current and future risks including risks to patient safety. The practice did not have sufficient processes to manage current and future performance.	

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care, however they were areas where this was limited.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: The involvement of the Patient Participation Group was limited and the practice could not evidence their involvement. The practice were not able to evidence the contribution of staff views in the planning and delivery of services. There was little evidence demonstrated of stakeholder involvement or engagement at the practice apart from the working that was being developed on delivering care in accordance to the Ealing Standards of care.	

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.	N
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence: There was no evidence of systems and processes to support learning, continuous improvement and innovation.	

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 Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	No statistical variation	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
6	No data	Null

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.
- 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.

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>

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.