

Care Quality Commission

Inspection Evidence Table

Lakeside Healthcare at Headlands (1-6017885884)

Inspection date: 10 September 2021

Date of data download: 01 September 2021

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

Overall rating: Good

At our previous inspection published in March 2020, we rated Lakeside Healthcare at Headlands as Requires Improvement overall. This was because we found:

- The practice did not have a proactive team approach to the shared care of frail elderly people with multiple co-morbidities which included cancer and frailty. Palliative care meetings were not held and there were no personalised care plans in place.
- The practice was not able to demonstrate that they used a clinical tool to identify older patients who were living with moderate or severe frailty.
- The percentage of women eligible for cervical screening was below the national average of 80%.
- Exception reporting for patients with long term conditions was above the CCG and national averages.
- Not all governance systems in place were effective.
- Not all the processes for managing risks, issues and performance were effective.
- The practice did not always act on appropriate and accurate information.

At this inspection carried out during September 2021, we rated this practice as Good. This was because:

- We found that the practice had implemented and sustained the improvements necessary.

Safe

Rating: Good

Safety systems and processes

The practice had 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.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• We saw that safeguarding policies and procedures were up to date and accessible for all staff.• The practice demonstrated that all clinical staff had been trained to the appropriate safeguarding level three. We found all non-clinical staff had received safeguarding training level one.• All staff had received appropriate DBS checks.• We saw that all staff who acted as chaperones had received appropriate training.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• We reviewed a sample of four staff personnel files during our on-site visit, and we found that appropriate checks had been carried out.	

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: 14/01/2021.	Y
There was a record of equipment calibration. Date of last calibration: 14/01/2021.	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
A fire risk assessment had been completed. Date of completion: 02/09/2021.	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We found that safety systems were appropriate, and that there were detailed records to support these. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 09/02/2021.	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 02/09/2021.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Identified actions from the risk assessment had been carried out and completed. Staff told us they found the additional measures implemented as a response to the COVID-19 pandemic had helped to keep staff and patients safe. This included the use of personal protective equipment and social distancing in the reception and waiting areas. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 16/08/2021.	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice used a local cleaning company and staff told us any identified concerns were resolved swiftly.• All staff had received suitable infection prevention and control training, including those responsible for leading on related areas.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Practice staff were able to describe appropriate actions in the event of patients deteriorating or becoming acutely unwell.	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.76	0.76	0.69	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2020 to 30/06/2021) (NHSBSA)	7.8%	9.0%	10.0%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2021 to 30/06/2021) (NHSBSA)	4.38	5.18	5.38	Tending towards variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	140.0‰	128.0‰	126.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	0.80	0.66	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	11.6‰	7.6‰	6.7‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
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.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> As part of this inspection we completed a range of clinical searches. We found that patients, including those using Disease-Modifying Anti Rheumatic Drugs (DMARDs, which are a class of drugs designed to influence the course of a disease which require regular monitoring) and high-risk drugs, were monitored appropriately. We reviewed a random sample of five patient notes, and we found that medicines reviews had been carried out appropriately. Clinical records viewed included information demonstrating safe and effective management of patients care. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	46
Number of events that required action:	4
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice used a comprehensive risk management, quality and compliance software system to manage and support performance, compliance and governance. This included recording, managing, communicating, and responding to significant events. 	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Positive COVID-19 test result within the practice staffing team.	Actions included carrying out COVID 19 tests with colleagues; establishing timelines; liaising with the local Clinical Commissioning Group (CCG); self-isolation for affected staff; reviewing and communicating related COVID 19 policies including PPE and social distancing measures.
Relative of a deceased patient contacted offering a COVID 19 vaccine – staff involved were unaware patient had recently passed away.	Actions included contacting and apologising to relative; reviews of communications processes; reviewing and identifying learning points from incident.

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: <ul style="list-style-type: none"> The practice had suitable systems to receive and distribute Medicines & Healthcare products Regulatory Agency (MHRA) patient safety alerts. We saw that safety alerts had received appropriate responses, including being shared with staff and discussed during meetings. 	

Effective

Rating: Good

At our previous inspection published in March 2020, we rated Lakeside Healthcare at Headlands as Requires Improvement for Effective services. This was because:

- The population groups of older people, people with long term conditions, working age people (including those recently retired and students), people whose circumstances make them vulnerable and people who because the population groups of long term conditions and working age people (including those recently retired and students) and people experiencing poor mental health (including people with dementia) were rated as Requires Improvement.
- The practice did not have a proactive team approach to the shared care of frail elderly people with multiple co-morbidities.
- The practice was not able to demonstrate that they used a clinical tool to identify older patients who were living with moderate or severe frailty.
- The practice did not provide evidence of a suitable response for addressing a cervical screening rate which was below target.
- The practice did not provide evidence of a suitable response for addressing some high levels of exception reporting.

At this inspection carried out during September 2021, we rated the practice as Good for providing Effective services. This was because the practice had implemented and sustained the improvements required.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y

There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We found that actions from MHRA alerts had been completed in line with safety recommendations. • The practice had suitable, personalised care plans for patients on the palliative care register. 	

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> • The practice used a suitable clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. • The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. • The practice carried out structured annual medicines reviews for older patients. • Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. • Health checks, including frailty assessments, were offered to patients over 75 years of age. • Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Good

Findings
<ul style="list-style-type: none"> • Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. • Staff who were responsible for reviews of patients with long-term conditions had received specific training and were receiving suitable supervision. • Members of the practice nurse team acted as a lead and had additional responsibility for diabetes and cardiology, and the practice was supporting further specialist training. • The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions. • The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. • Adults with newly diagnosed cardio-vascular disease were offered statins.

- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- 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)	77.4%	77.7%	76.6%	No statistical variation
PCA* rate (number of PCAs).	23.4% (206)	13.0%	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)	91.5%	88.7%	89.4%	No statistical variation
PCA rate (number of PCAs).	24.7% (62)	14.8%	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)	78.3%	81.5%	82.0%	No statistical variation
PCA* rate (number of PCAs).	7.8% (20)	5.8%	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)	75.4%	69.9%	66.9%	No statistical variation
PCA rate (number of PCAs).	21.1% (124)	20.1%	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)	76.9%	74.3%	72.4%	No statistical variation

PCA rate (number of PCAs).	23.2% (297)	8.4%	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)	91.9%	94.2%	91.8%	No statistical variation
PCA rate (number of PCAs).	3.9% (7)	3.9%	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)	80.8%	76.4%	75.9%	No statistical variation
PCA rate (number of PCAs).	21.0% (123)	12.5%	10.4%	N/A

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

Any additional evidence or comments

- Practice staff (including GPs and managers) were aware that some PCA rates (historical data from 01/04/2019 to 31/03/2020) were shown as being higher than comparators.
- Practice staff had initiated a range of approaches to investigate and respond to Personalised Care Adjustments (PCAs, which replaced the previous exception reporting approach). This included targeted meetings; using IT system functionality to support prioritising patient contact and appointments booking; and reviewing the data for incorrectly coded data. Those subject to PCAs were reviewed by a clinician and the practice was carrying out reviews and audits of PCAs.

Families, children and young people

Population group rating: **Good**

Findings

- The practice had met the minimum 90% target for all childhood immunisation uptake indicators, and had met the World Health Organisation (WHO) national target of 95% (the recommended standard for achieving herd immunity) for three out of five childhood immunisation uptake indicators.
- The practice 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.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for those within this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	118	125	94.4%	Met 90% minimum
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)	89	92	96.7%	Met 95% WHO based target
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)	89	92	96.7%	Met 95% WHO based target
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)	90	92	97.8%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	130	138	94.2%	Met 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Working age people (including those recently retired and students)

Population group rating: **Good**

Findings

- 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.
- The practice's cervical cancer screening figure was below the 80% target uptake rate. The practice demonstrated they were committed to improving the uptake of cervical screening and had implemented a range of approaches to improve this. This included increased and more flexible use of appointments; the use of an appointment template to act as a prompt to discuss cervical screening; and proactive targeting of patients who did not attend initial screening appointments. The practice also provided evidence of how they used cultural awareness and sensitivity when addressing cervical screening with patients. There was a dedicated noticeboard and health promotion for cervical screening, which contained appointment details and awareness posters.
- The practice recognised they had a population where some patients' culture may have contributed to a lower uptake of screening appointments and was working with the community to address this.
- The practice used early morning appointments to ensure those patients who were working could access appointments easily. Patients could book or cancel appointments online and order repeat medication without the need to attend the practice site.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2021) (Public Health England)	73.2%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	74.8%	74.2%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	63.1%	63.2%	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)	97.6%	94.4%	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)	44.0%	52.9%	54.2%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- 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: Good

Findings

- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long term medicines.
- 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. We found that patients had care plans and that patients on the dementia register had received a review in the last 12 months.
- All staff had received appropriate dementia training and updates.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) ^(QOF)	90.1%	87.5%	85.4%	No statistical variation
PCA* rate (number of PCAs).	31.7% (33)	24.0%	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) ^(QOF)	77.9%	82.0%	81.4%	No statistical variation
PCA rate (number of PCAs).	14.0% (14)	11.6%	8.0%	N/A

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

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	England average
Overall QOF score (out of maximum 559)	559	533.9
Overall QOF score (as a percentage of maximum)	100%	95.5%
Overall QOF PCA reporting (all domains)	9.6%	5.9%

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

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

We saw that the practice had an audit plan and associated programme of activity. Recent examples included:

- An investigation into the characteristics, symptoms, responses to and resources associated with treating “Long COVID”. This resulted in improved patient treatment; improved referrals to specialist clinics; and improved recording. There were additional reported benefits in associated staff knowledge and awareness.
- We saw evidence of a wound care audit where findings had been used to implement changes which led to reported improvements in treatment, care planning, recording, and staff knowledge.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We saw evidence that staff were suitably experienced, trained, supported, and supervised in order to carry out their roles. • Regular and appropriate clinical supervision was provided for nursing staff. 	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y

Caring

Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had a 'Transgender Patient Care Policy', which included consideration of legislation; preferences; and consent.	

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	95.4%	88.3%	89.4%	Tending towards variation (positive)
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)	90.6%	87.6%	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)	100.0%	94.6%	95.6%	Significant Variation (positive)
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)	88.9%	82.3%	83.0%	No statistical variation

Any additional evidence or comments

The practice scored above national and local comparators for National GP Survey results relating to listening, care and concern, and confidence and trust.

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

Any additional evidence

The practice actively sought feedback, and sent out feedback form to patients.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had a large number of notice boards which provided information on resources and other services locally. 	

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 (01/01/2021 to 31/03/2021)	91.8%	92.5%	92.9%	No statistical variation

	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice provided services and supporting information in a range of languages used by the local community. This included for example providing dietary advice and menu planning for non-English speaking diabetic patients. The practice website contained a wide range of information for patients and the wider public, including links to practice policies and procedures. 	

Carers	Narrative
Percentage and number of carers identified.	There were 235 carers on the practice carers register; which equates to just over 2% of the patient population.
How the practice supported carers (including young carers).	<p>The practice had a range of approaches to support carers. This included:</p> <ul style="list-style-type: none"> Having an allocated carer's champion, who had experience outside of a work setting of being a carer. Establishing and maintaining effective relationships with local stakeholders involved with supporting carers. Capturing carer status as part of patient health checks, appointments, and new patient registrations. Prioritising services for carers. Holding and contributing to dedicated carers events locally. Providing resources and information for carers. <p>As a result of these approaches the practice had achieved the Silver Award in the GP carers accreditation scheme. The practice was committed to working towards Gold Award status.</p>
How the practice supported recently bereaved patients.	<p>Information regarding bereavement counselling was available to patients.</p> <p>The practice sent bereavement cards to those affected by bereavement.</p>

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> During the previous inspection published in March 2020 we found that confidentiality could not always be maintained at the reception desk. During this inspection, we found that the practice had implemented a process whereby patients could be spoken with at the reception desk in private. There were also private rooms available if needed. 	

Responsive

Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs/ Services did not meet patients' needs.

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

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 8pm
Wednesday	8am to 6.30pm
Thursday	8am to 8pm
Friday	8am to 6.30pm
Appointments available:	
Monday	8.30am to 5.30pm
Tuesday	8.30am to 8pm
Wednesday	8.30am to 5.30pm
Thursday	8.30am to 8pm
Friday	8.30am to 5.30pm
Extended Hours	
Tuesday and Thursday until 8pm.	

Older people

Population group rating: Good

Findings

- The practice had a social prescriber who supported the provision of a holistic approach to people's health, wellbeing and social welfare by supporting and signposting to local support groups. We saw evidence of positive outcomes associated with this, including where individual patients had seen sustained improvements in their circumstances. We saw that the social prescriber had contacted approximately 400 patients aged 75 and older during COVID-19 lockdown restrictions.
- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community clinicians to discuss and manage the needs of patients with complex medical issues.
- Practice clinicians held regular clinics to review and manage patients with complex wounds and leg ulcers.
- During our previous inspection, we found that the practice could not demonstrate that care and treatment for people with long-term conditions approaching the end of life was consistently coordinated with other services. During this inspection, we found that the practice had implemented and maintained improvements in this area. This included re-establishing palliative care meetings, improving personalised care planning, and establishing lead staff. The practice had introduced the consistent use of a frailty tool, and was engaging with other services in a more consistent way.

Families, children and young people

Population group rating: Good

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 where this was possible and deemed necessary.
- The practice offered a comprehensive family planning and contraception service.
- The practice hosted midwives from a local hospital who ran ante-natal clinics at the practice.

Working age people (including those recently retired and students)

Population group rating: Good

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.
- The practice was open until 8pm on a Tuesday and Thursday.
- Pre-bookable appointments were available to all patients at additional locations within the area, as the practice was a member of a local GP federation.
- The practice offered minor surgery appointments to reduce referrals to the local hospital and delays in care and treatment.
- The practice used social media channels to inform patients about cervical screening, immunisations and vaccinations and medication reviews.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- There was a social prescriber who had worked at the practice for over a year, and who was embedded and integrated into the practice's ways of working. They supported the practice to provide a holistic approach to people's health, wellbeing and social welfare by supporting and signposting people to local support groups. We saw qualitative and quantitative evidence of sustained positive outcomes for service users, for example patients being involved in the maintenance of a local community allotment before and after COVID-19 lockdown restrictions. We saw evidence of the social prescriber having contacted hundreds of patients to offer support, and we saw evidence of how around 70 patients had experienced improvements in their circumstances as a result of this work.
- The practice held a register of patients living in potentially 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 permanent address.
- Local homeless people were supported by being transported to a neighbouring practice for a COVID 19 vaccination. Further support was also provided at this and the neighbouring practice, including providing guidance and information, offering GP appointments, and carrying out Hepatitis C testing.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

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

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- All clinical staff had completed training on the Mental Capacity act.
- The practice was aware of support groups within the area and signposted their patients to these appropriately.
- Patients were able to access a counsellor who held clinics at the practice site.
- Staff had received dementia training and could access specialist guidance.

Access to the service

People were 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.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
There were systems in place to support patients who face communication barriers to access treatment.	Y
Patients with urgent needs had their care prioritised.	Y
The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.	Y

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)	74.4%	N/A	67.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	64.4%	69.0%	70.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	66.3%	64.3%	67.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	70.8%	81.2%	81.7%	No statistical variation

Any additional evidence or comments

Staff told us that they were in the process of implementing a new telephone management system which had improved functionality and would support improved access.

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.	130
Number of complaints we examined.	Five
Number of complaints we examined that were satisfactorily handled in a timely way.	Five
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Nil.

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Approximately 60% of complaints made to the practice in the last 12 months were made within a three-month period, and were related to access and face-to-face appointments. The practice had only received around 10% (of the complaints made in the last 12 months) during the last two months.• We saw evidence that practice staff had made attempts to communicate with patients regarding how they could access care and treatment during the implementation of COVID-19 measures. This included consideration of those who may be digitally excluded.• Information relating to complaints was readily available on-site and on the practice website.• Complaints were managed using the practice's compliance software system.• We saw evidence that practice staff discussed complaints during meetings.	

Well-led

Rating: Good

At our previous inspection published in March 2020, we rated Lakeside Healthcare at Headlands as Requires Improvement for Well-led services. This was because:

- Not all governance systems in place were effective.
- Not all the processes for managing risks, issues and performance were effective.
- The practice did not always act on appropriate and accurate information.

At this inspection carried out during September 2021, we rated this practice as Good for providing Well-led services. This was because the practice had implemented and sustained the improvements required.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• We saw evidence that the management team were aware of and had responded to challenges as well as issues identified following our previous inspection.• All staff we spoke with told us they felt able to approach senior colleagues with any questions and/or concerns.	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:	

- All staff we spoke with told us they were consulted and engaged in terms of developments.

Culture

The practice had a culture which drove high quality sustainable care

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

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

Source	Feedback
Staff interviews and feedback	<p>All staff we spoke with were positive about working at the practice, and from the support received from the management team.</p> <p>Some staff told us they or colleagues had experienced very high levels of support and care from senior staff and other colleagues when this was needed, for example when experiencing personal challenges, illness or bereavement.</p>

Governance arrangements

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

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

There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw evidence of sufficient arrangements to support good governance and management. This included:</p> <ul style="list-style-type: none"> • Suitable systems to manage the response to Medicines & Healthcare products Regulatory Agency (MHRA) patient safety alerts. • Appropriate systems to manage risks and issues associated with the premises and equipment. 	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw evidence of sufficient arrangements to support the management of risks, issues and performance. This included:</p> <ul style="list-style-type: none"> • Processes to identify and address practice performance, including Personalised Care Adjustment (PCA) results and patient screenings. • The practice had a suitable emergency response and business continuity plan which was accessible remotely. 	

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y

The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
The practice were using data and information effectively to support decision making and actions, including MHRA patient safety alerts; Personalised Care Adjustment (PCA) results; and patient screenings data.	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y

The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice had established a patient participation group (PPG) which had met within the last month, and there were future meetings planned. The next meeting was scheduled for September 2021. 	

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice engaged with other practices within the Lakeside group to share learning and best practice. The practice worked to a programme of audits, which included two cycles and appropriate dissemination and sharing of findings and learning points. 	

Examples of continuous learning and improvement

- Following patient treatment, further specialist training was provided to the staff team relating to ulcer management. This also included some shadowing at a local foot clinic.
- The practice is a training practice for medical students from Cambridge, and also provides training for GP Registrars. This facilitates effective two-way sharing of learning and best practice.
- One of the GPs at the practice is a representative for the local primary care network.

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 practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **PHE:** Public Health England.

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