

# Care Quality Commission

## Inspection Evidence Table

### Regent Square Group Practice (1-559800210)

Inspection date: 26 May 2021

Date of data download: 19 May 2021

## Overall rating: Requires improvement

We inspected the practice on 11 February 2020 and rated the practice requires improvement overall and for the provision of safe and well-led services. A requirement notice was issued for a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities). We followed up the enforcement action with an announced focused inspection on 26 May 2021. We found that the practice had made improvements in relation to the breaches in regulation, however we identified other areas of concern. The practice was rated as requires improvement overall, inadequate for the safe key question and requires improvement for the effective key question. It was rated as good for the provision of caring, responsive and well led services.

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

## Safe

## Rating: Inadequate

When we inspected the practice on 11 February 2020, we rated the practice as requires improvement for providing safe services due to gaps in fire safety and safeguarding training, not all patient group directions (PGDs) were up to date, there was no risk assessment for emergency medicines and two healthcare assistants shared a room to deliver a phlebotomy service. An appropriate risk assessment had not been carried out to ensure discussions about care treatment and support only take place where they cannot be overheard.

At the inspection in May 2020 we rated the practice as inadequate for safe services because:

- We found that improvements had been made in relation to the previous breaches of regulation. However, we found additional areas of concern. Therefore, the practice did not have effective systems for the appropriate and safe use of medicines, including medicines optimization.

### 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

Safeguarding	Y/N/Partial
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
<p>At the inspection in February 2020 we found:</p> <ul style="list-style-type: none"> <li>Some staff were vague about how to access policies and procedures.</li> <li>The practice had obtained DBS checks for most staff. One member of staff had not had a recent DBS check or chaperone training and had acted as a chaperone recently. The practice manager confirmed a DBS check would be completed and non-clinical staff do not act as chaperones, this was the role of healthcare assistants or nurses. The healthcare assistants confirmed they had received chaperone training.</li> </ul> <p>At the inspection in May 2021 we found:</p> <ul style="list-style-type: none"> <li>The four members staff who completed interview templates as part of this inspection process confirmed they knew how to access policies and procedures.</li> <li>We looked at recruitment files for four staff employed since the last inspection and found DBS checks had been obtained for all four.</li> <li>Three non-clinical members of staff confirmed chaperoning is the role of the health care assistants.</li> <li>All staff were up to date with safeguarding training.</li> </ul>	

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.	P
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in February 2020 we found:</p> <ul style="list-style-type: none"> <li>The practice had obtained DBS checks for most staff. One member of staff had not had a recent DBS check.</li> </ul> <p>At the inspection in May 2021 we found:</p>	

- All staff had received a DBS check in the four recruitment files we checked.

Additionally, we found:

- Other than for one nurse, there was no record of up to date vaccinations and immunisation training (the practice manager confirmed this was done at target training sessions). Evidence was requested, but not submitted by the practice.
- There were systems to ensure the registration of clinical staff was checked on recruitment but there was no evidence they were regularly monitored to ensure they remained current. The practice manager told us the checks were completed, but they were not recorded. The last check we saw was for 2015. The practice manager agreed to document the checks in future. Following the inspection, the practice manager confirmed a system was in place.

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: 18 May 2021	Y
There was a record of equipment calibration. Date of last calibration: 18 May 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: 31 March 2021	Y
Actions from fire risk assessment were identified and completed.	Y

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 28 January 2021	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 28 January 2021	Y

### 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: May 2021	Y

The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection in February 2020 we found:</p> <ul style="list-style-type: none"> <li>Required improvements had not been identified in the IPC audit.</li> </ul> <p>At the inspection in May 2021 we found:</p> <ul style="list-style-type: none"> <li>Infection Prevention and Control (IPC) audits were being completed with details of findings being addressed.</li> </ul> <p>Additionally, we found:</p> <ul style="list-style-type: none"> <li>Although IPC audits were being completed, they were not always timely, for example, an environmental cleanliness audit were completed in August 2020, February 2021 and May 2021. The audit said it should be completed weekly. The decontamination of equipment audit was completed April 2020, November 2020 and April 2021. The audit said it should be completed monthly. The practice manager agreed the frequency of the audits would be reviewed with the IPC lead.</li> <li>We saw some of the décor and fixtures and fittings may not be able to be cleaned effectively. For example, in the healthcare assistants (HCA) consulting/treatment room the flooring was worn and stained and needed replacing and some paint work in a GP consulting room was damaged. The practice manager confirmed this was being addressed. We also discussed the practice developing a five-year refurbishment plan.</li> <li>A written risk assessment for IPC in relation to Covid-19 was unavailable on the site visit and not submitted as part of the inspection process. However, the practice manager told us what systems they had in place to minimize risk and we also observed these. Systems included provision of hand sanitisers, screens at reception, ventilation and personal protection equipment.</li> </ul>	

## 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.	N/A
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
<p>At the last inspection in February 2020 we found:</p> <ul style="list-style-type: none"> <li>We observed two healthcare assistants shared a room to undertake routine tests, such as bloods. There was a curtain in the middle of the room to act as a divide. Patients were seen with each healthcare assistant at the same time. The management team explained if patients wished to speak with a clinician privately they could do so outside of this treatment room. However, this did</li> </ul>	

not allow patients to speak openly or raise any concerns mental health, domestic abuse, etc. It also compromised patient confidentiality.

At the inspection in May 2021 we found:

- At the site visit we saw the room was still set up to be used for two healthcare professionals. However, we received assurances from the practice manager the room was used for the baby clinic and not to deliver a phlebotomy service by two healthcare assistants.
- All non-clinical staff were trained and skilled in various areas to ensure continuity and work on a rotational basis. They also worked part time for flexibility and to cover annual leave.
- All non-clinical staff had received training in sepsis.

## 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.	P
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Some patients who were prescribed Disease-modifying antirheumatic drugs (DMARDs), were monitored by the hospital, there was no evidence the results were reviewed by the practice as it was not recorded in the patient's records.</li> </ul>	

## Appropriate and safe use of medicines

### The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/01/2021) (NHS Business Service Authority - NHSBSA)	0.82	0.75	0.70	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2020 to 31/03/2021) (NHSBSA)	13.1%	7.5%	10.2%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2020 to 31/03/2021) (NHSBSA)	6.52	5.36	5.37	Tending towards variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	191.2‰	165.6‰	127.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	0.99	0.42	0.66	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	P
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	P
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.	NA
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	N
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	NA

Medicines management	Y/N/Partial
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	NA
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.	NA
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.	P
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> <p>At the last inspection in February 2020 we found:</p> <ul style="list-style-type: none"> <li>• The practice had Patient Group Directions (PGDs) in place, however four were out of date.</li> <li>• The practice did not stock all recommended emergency medicines and an appropriate risk assessment had not been carried out to identify a list of medicines that are not suitable for a practice to stock.</li> </ul> <p>At the inspection in May 2021 we found:</p> <ul style="list-style-type: none"> <li>• We viewed 12 PGDs and these were up to date and signed.</li> <li>• The practice had completed a risk assessment to determine which medicines they hold to deal with a medical emergency.</li> </ul> <p>Additionally, we found:</p> <ul style="list-style-type: none"> <li>• The authoriser had signed the PGDs before some staff had sight of them in three of the 12 viewed. The practice manager agreed all staff would sign to say they were competent before the PGD was authorised. Following the inspection, the practice manager confirmed a system had been implemented.</li> <li>• There was no stock record for some medicines, such as local anaesthetic, an injectable anti-inflammatory, various eyedrops and depo contraceptives and had not been risk assessed. The practice manager agreed to review. Following the inspection, the practice manager confirmed a system had been implemented.</li> <li>• We saw records to demonstrate the defibrillator was checked, but there were no records of checks for the oxygen cylinders. We were told visual checks were completed daily but not recorded. The practice manager agreed to document.</li> <li>• We saw there were some systems in place to store blank prescriptions safely. We saw prescriptions were stored in one GP consulting room in an unlocked cupboard and printer although they were in a locked room. It is not advisable to leave the forms in an unlocked cupboard/printer. Records of the stored prescriptions were clear where they were distributed by the reception staff but not for the incoming/outgoing stored boxes.</li> </ul>	



Medicines management	Y/N/Partial
<ul style="list-style-type: none"> <li>There was no evidence of monitoring high risk medicines. For example, we reviewed data for a high-risk medicine used to prevent blood clots. 244 patients had been prescribed this class of medication, 184 patients (75%) had not received the required monitoring. We also reviewed data for a high risk medicines prescribed to reduce high blood pressure. We saw 227 patients had not received annual blood tests. The provider told us that these patients would be reviewed with immediate effect.</li> <li>There was no evidence of oversight of prescribing for Disease Modifying Anti-Rheumatic Drugs (DMARD). We saw no evidence in patient records that the prescriber had checked records for patients prescribed methotrexate, and recorded monitoring was up to date prior to issuing a prescription. 24 patients had been prescribed this medication and 17 patients (71%) had not had any monitoring of their bloods. We also looked at records of patients who had been prescribed another DMARD medication, Azathioprine. Four patients had been prescribed the medication, we reviewed three patient records (75%) and saw no evidence patients had been monitored. The provider explained blood test results were recorded and monitored by secondary care. There was no evidence results were reviewed by the practice as the results were not recorded in the patient's records. The provider told us that these patients would be reviewed with immediate effect.</li> <li>Following this inspection, we asked the practice for confirmation patients had received a review and evidence of action they had taken regarding monitoring of high risk medicines and oversight of prescribing for DMARDS and no evidence was submitted.</li> </ul>	

## 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: 8	Y
Number of events that required action: 8	

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

Event	Specific action taken
Patient confidentiality	Practice investigated and apologised to the patient.
COPD exacerbation, incorrect dosage of inhaler prescribed by the out of hours (OOH) service.	Reported to OOH service. Nurse informed patient of correct dose for the prescribed inhaler.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	P



Staff understood how to deal with alerts.	Y
Safety alerts were received by a designated reception email, the assistant practice manager would then disseminate to relevant staff for either information or action. All applicable safety alerts were discussed at the partners meeting and nurse's meetings. Both meetings were minuted and shared with staff.	
We saw examples of actions taken on recent alerts. However, from our system searches during this inspection we saw the practice did not routinely check historical alerts. We saw two patient safety alerts whereby patients had not been informed of the risks of the medication. For example, contraindications of a medicine use to lower blood sugar in adults with type 2 diabetes, a medicine used to treat high blood pressure and one used to lower cholesterol being prescribed together The provider told us that these patients would be reviewed with immediate effect.	

## Effective improvement

## Rating:

## Requires

When we inspected the practice on 11 February 2020, we rated the practice as good for effective and for all population groups.

Following the inspection in May 2021 we rated the practice as requires improvement for effective and requires improvement for the following population groups; people with long term conditions, working age people, children, families and young people and people whose circumstances make them vulnerable because:

- Patients' needs were assessed, but care and treatment were not always delivered in line with current standards and evidence-based guidance in relation to reviews of patients with long term conditions and a learning disability.
- Some performance data was below local and national averages and evidence overtime showed the practices attainment had been declining pre-covid in relation to cancer screening and childhood immunisations.
- The practice did not routinely review through quality improvement the effectiveness and appropriateness of the care provided in order to provide effective, safe care.
- Some performance data was below local and national averages and evidence overtime showed the practices attainment had been declining pre-covid in relation to cancer screening and childhood immunisations.

### 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.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N
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
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in May 2021 we found:</p> <ul style="list-style-type: none"> <li>We saw evidence of registers for people with a learning disability, mental health condition, long term conditions, palliative, carer etc. However, there was no clear evidence of learning disability checks.</li> </ul>	

## Older people

## Population group rating: Good

Findings
<ul style="list-style-type: none"> <li>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. Patients identified were also discussed at the proactive care meetings.</li> <li>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.</li> <li>The practice carried out structured annual medication reviews for older patients.</li> <li>Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.</li> <li>Health checks, including frailty assessments, were offered to patients over 75 years of age.</li> <li>Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group. The practice nurse team visited housebound patients to administer flu vaccinations.</li> <li>The practice offers flexible appointments for patients who rely on public transport taking in to account transportation timetables.</li> <li>Over 75s have a named GP.</li> <li>The practice participates in the Proactive Care Service, whereby individual care plans are tailored to suit the holistic and health needs of the patient. This includes liaising with outside agencies, such as adult social care, social prescribing, living well, ageing well, local geriatrician and carers UK.</li> </ul>

## People with long-term conditions

## Population group rating: Requires improvement

Findings
<p>At the inspection in May 2021 we rated this population group as requires improvement because we found care and treatment were not always delivered in line with current standards and evidence-based guidance in relation to reviews of patients with long term conditions.</p> <ul style="list-style-type: none"> <li>Some patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. However, we reviewed data for a high-risk medicine used to prevent blood clots. 244 patients had been prescribed the medication, 184 patients had not received the required monitoring. We also reviewed data for a high-risk medicine prescribed to reduce high blood pressure. We saw 227 patients had not received annual blood tests.</li> <li>Staff who were responsible for reviews of patients with long-term conditions had received specific training.</li> </ul>

- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared 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.
- Patients with COPD were offered rescue packs.
- The practice had a fibromyalgia support group for patients which was led by the salaried GP. This was a coffee morning for patients to share experiences on how they manage their condition and information was also available to support them. This group was paused due to the covid pandemic and the practice are hoping to relaunch it in June 2021.
- Patients with asthma were offered an asthma management plan.
- The practice held quarterly (multidisciplinary where possible) palliative care meetings. Quarterly MDT meetings with Community Nurses/ Palliative Team / MacMillan for Palliative Care patient reviews.
- A GP Partner had completed health coaching certification (for healthcare professionals) and was studying towards the British Society of Lifestyle Medicine Diploma, which promotes evidence-based lifestyle interventions. This often facilitates de-prescribing, which is cost-effective, and more desirable to patients. Health coaching and motivational interviewing helps to empower and educate patients, identify their individual health priorities and support strategies for change. The practice, with the support of a volunteer Health and Lifestyle Coach/ Practitioner, were currently in the process of identifying a cohort of patients with Type 2 Diabetes and obesity for the lifestyle intervention pilot.

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)	71.0%	76.5%	76.6%	No statistical variation
PCA* rate (number of PCAs).	6.5% (52)	10.8%	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)	90.5%	88.5%	89.4%	No statistical variation
PCA rate (number of PCAs).	5.5% (13)	11.2%	12.7%	N/A

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	81.0%	84.4%	82.0%	No statistical variation
PCA rate (number of PCAs).	3.8% (7)	4.2%	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) <small>(QOF)</small>	78.3%	71.9%	66.9%	Tending towards variation (positive)
PCA rate (number of PCAs).	25.0% (146)	14.1%	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) <small>(QOF)</small>	75.4%	75.1%	72.4%	No statistical variation
PCA rate (number of PCAs).	3.5% (36)	5.2%	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) <small>(QOF)</small>	92.3%	92.5%	91.8%	No statistical variation
PCA rate (number of PCAs).	2.9% (5)	4.0%	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) <small>(QOF)</small>	86.2%	80.2%	75.9%	Tending towards variation (positive)
PCA rate (number of PCAs).	8.2% (48)	8.5%	10.4%	N/A

## Families, children and young people

## Population group rating: Requires improvement

### Findings

At the inspection in May 2021 we rated this population group as requires improvement because the practice had not met the minimum 90% target for two out of five of childhood immunisation uptake indicators. Evidence over time showed the practices attainment had declined due to covid.

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

- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.
- Flexible appointments for after school

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)	83	97	85.6%	Below 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)	118	129	91.5%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	118	129	91.5%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	119	129	92.2%	Met 90% minimum
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)	90	109	82.6%	Below 90% minimum

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

#### Any additional evidence or comments

- The practice was aware they had not met the minimum target of 90% for two of the childhood immunisation uptake indicators and were taking action to address this. For example, they held a well-baby clinic on a Thursday afternoon 2.00pm – 3.00pm (walk in) for baby and pre-school children immunisations. They also had flexible appointments after school. A year ago, they ran a list of vaccinations and passed the information to school nurses and health visitors. Babies/preschool children who did not attend were followed up by letter and a phone call. Parents were encouraged to attend the walk-in clinic, but a pre-booked appointment could also be arranged.

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

## Population group rating: Requires improvement

### Findings

At the inspection in May 2021 this population group was rated as requires improvement due to low cancer screening attainment rates. The practices cancer screening attainment had decreased since the last inspection in February 2020 from 73.7% to 69.4% and had not met the 80% minimum target. Evidence over time showed the practices attainment in this area had been declining pre-covid.

- 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. However, we saw evidence this was with the exception of people with a learning disability.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- The practice was accessible to the working population group. The practice manager said telephone consultations had been a positive change to patient care, patients did not have to attend surgery or book annual leave to attend an appointment. They offer same day triage, online appointments and flexible telephone calls at a time to suit the patient.
- The practice had a minor illness clinic for same day treatment by nurse / practice pharmacist for minor ailments.
- Extended Access - available at 'Hubs' on a weekday evening and a Saturday morning for pre-bookable appointments via the practice.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/12/2020) (Public Health England)	69.4%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	74.9%	71.6%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2019 to 31/03/2020) (PHE)	61.4%	N/A	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)	95.0%	90.4%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two	50.0%	43.8%	54.2%	No statistical variation



week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)				
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### Any additional evidence or comments

At the inspection in February 2020 the practice was trying to address their low attainment by using letters, text messaging, recalls, extended hours and opportunistically reminding patients. At this inspection the practice said they have extended hours on Wednesdays from 7am until 7pm. They were working with their Primary Care Network to look at offering Saturday morning appointments.

### People whose circumstances make them vulnerable

### Population group rating: Requires improvement

#### Findings

At the inspection in May 2021 we rated this population group as requires improvement because we found care and treatment were not always delivered in line with current standards and evidence-based guidance in relation to reviews of patients with a learning disability. There was no clear evidence patients with a learning disability were offered an annual health check.

- Same day appointments and longer appointments were offered when required.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice used pictorial appointment invites.
- The practice had close working relationship with external agencies, such as Aspire (local Drugs and Alcohol Service) and one of the practice partners undertakes sessions there.

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

### Population group rating: Good

#### Findings

- 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' 14 services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.

- 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) <small>(QOF)</small>	97.3%	81.2%	85.4%	No statistical variation
PCA rate (number of PCAs).	18.0% (16)	22.4%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	91.8%	80.9%	81.4%	No statistical variation
PCA rate (number of PCAs).	14.1% (10)	11.4%	8.0%	N/A

### Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	555.9	Not Available	533.9
Overall QOF score (as a percentage of maximum)	99.4%	Not Available	95.5%
Overall QOF PCA reporting (all domains)	6.3%	Not Available	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	P
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	P
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 one single cycle clinical audit with actions identified for improvement.  
The second audit we viewed showed a review of referrals with no actions for improvement.

### Any additional evidence or comments

- Audit activity had declined since the last inspection. The provider told us during the covid pandemic resources had reduced, such as staff sickness and nurses allocated to support the covid vaccination hubs. They said they will prioritise the audit programme. To support the programme they will have access to two pharmacists four days a week within the next couple of weeks/months.

### Effective staffing

**The practice was able to demonstrate 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
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection in February 2020 we found:</p> <ul style="list-style-type: none"> <li>• One non-clinical staff member had worked outside of their level of competence. For example, they had recently acted as a chaperone without any chaperone training. The practice assured us non-clinical staff were never alone with a patient and never acted as a chaperone.</li> <li>• There was a basic system in place to monitor staff training. The practice manager said they would strengthen the system by implementing a training matrix. We were told mandatory training included CPR, fire safety, infection prevention and control and safeguarding. There were some gaps in staff mandatory training. Non-clinical staff had not received sepsis training, but staff were aware of what to do if a patient deteriorated.</li> <li>• Three clinical staff said they received annual appraisals. One out of two non-clinical staff we spoke with said they had not received an appraisal. We viewed two staff files and there was no record of appraisals in 2019. All staff we spoke to said they felt supported. The practice manager confirmed all appraisals were due in February 2020.</li> </ul> <p>At the inspection in May 2021 we found:</p> <ul style="list-style-type: none"> <li>• Staff were clear about their roles and responsibilities.</li> <li>• There was a system in place to monitor staff training and all staff were up to date with their training, including sepsis.</li> </ul>	

- We viewed staff files and staff also confirmed they had received appraisals. Staff said they felt supported, training/development needs were discussed, and the practice had an open-door policy.

## 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-centered care when they moved between services.	Y
Explanation of any answers and additional evidence:	

## Helping patients to live healthier lives

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

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

## Consent to care and treatment

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

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

Explanation of any answers and additional evidence:

## Well-led

## Rating: Good

When we inspected the practice in February 2020, we rated the practice requires improvement for providing well led services because there were no clear responsibilities, roles systems of accountability to support good governance and management and the provider did not have clear and effective processes for managing risks, issues and performance.

At the inspection in May 2021 we found the provider had taken all the necessary actions to address the previous shortfalls and were now compliant.

### 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"><li>The practice had expanded their partnership and were in the process of expanding the team further. The practice had succession plans in place. They had two new GP partners and were hoping to recruit an additional partner. They had additional clinical staff members including an advanced nurse practitioner (ANP) and two pharmacists who were due to start work in the near future.</li><li>Staff said they felt supported, part of a team and management were always approachable. They said all staff had pulled together to support each other during the pandemic and they felt part of a cohesive team.</li></ul>	

### 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:
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## Culture

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

	Y/N/Partial
There were arrangements to deal with any behavior 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 candor.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	
At the last inspection in February 2020 we found:	
<ul style="list-style-type: none"> <li>Staff had not received equality and diversity training in the last year.</li> </ul>	
At the inspection in May 2021 we found:	
<ul style="list-style-type: none"> <li>All staff were up to date with equality and diversity training.</li> </ul>	

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

Source	Feedback
Staff feedback	Staff said they had a really good relationship with all staff at different levels. They felt supported both personally and workwise.

## Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	



At the last inspection in February 2020 we found:

- Governance arrangements weren't effective, for example some staff were vague of how to access the practices policies and procedures, there was a basic system in place to monitor staff training, and four Patient Group Directives (PGD) had not been reviewed.
- Staff were not always clear on their roles and responsibilities, for example a member of the non-clinical team had recently acted as a chaperone and they had not received chaperone training. Staff were not always clear on what to do in the event of a medical emergency or how to ensure business continuity.

At the inspection in May 2021 we found:

- Staff knew how to access policies and procedures. There was a system to monitor staff training and all staff were up to date. The PGDs had been reviewed, but the authoriser had signed them before some staff had sight of them in three of the 12 viewed.
- Staff told us they were clear on their roles and responsibilities in relation to chaperoning and what to do in the event of a medical emergency.

## 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.	P
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y

Explanation of any answers and additional evidence:

At the last inspection in February 2020 we found:

- The practice had some assurance systems. For example, there was a basic system to monitor staff training.
- Three clinical staff said they received annual appraisals. One out of two non-clinical staff we spoke with said they had not received an appraisal. We viewed two staff files and there was no record of appraisals in 2019.
- An emergency medicines risk assessment had not been completed to assess which emergency medicines to stock. Required improvements had been identified in the IPC audit, however, there was no action plan in place on the day of inspection to address this.
- The practice had a business continuity plan in reception and in the practice managers office. However, some staff were not aware of the business continuity plan and where the emergency medicines were kept.

At this inspection in May 2021 we found:

- The practice had a system in place to monitor staff training.
- All staff had received annual appraisals.
- An emergency medicine risk assessment had been completed. However, the practice did not keep a stock record for some non-emergency medicines.
- Staff told us they were aware of the business continuity plans and knew how to access them.

Additionally, we found:

- Audit activity had declined (we saw one single cycle audit) since the last inspection. The provider told us during the covid pandemic resources had reduced, such as staff sickness and nurses allocated to support the covid vaccination hubs. They said they will prioritise the audit programme. To support the programme they will have access to two pharmacists four days a week within the next couple of weeks/months.

### **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. Would book them in face to face.	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
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in May 2021 we found:</p> <ul style="list-style-type: none"> <li>• The practice offered a range of appointment types to suit people's different needs, through triage and included face to face, telephone and video appointments. People had access to routine same day and next day appointments.</li> <li>• Data from the GP patient survey was positive and the practice had a high attainment against the indicators for access and patient experience.</li> <li>• The practice monitored daily appointments and would increase capacity and appointments should they need to.</li> </ul>	

## 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: At the inspection in February 2020 we found: <ul style="list-style-type: none"> <li>An emergency medicines risk assessment had not been completed to assess which emergency medicines to stock.</li> </ul> At the inspection in May 2021 we found: <ul style="list-style-type: none"> <li>An emergency medicine risk assessment had been completed. However, the practice did not keep a stock record for some non-emergency medicines.</li> </ul>	

## Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Video consultations were available to patients throughout the pandemic, the practice told us appointments were predominantly via telephone appointments.</li> </ul>	

## 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"><li>The practice's PPG meeting had been paused during the pandemic, however, they retained a good relationship and communication with them. They were looking to restart the PPG meetings at the end of June 2021.</li><li>The practice said they will resume patient surveys within the next few months and currently they received patient feedback through a text messaging service and their website.</li></ul>	

### Any additional evidence

## Continuous improvement and innovation

**There was evidence of 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"><li>The practice trained medical and nursing students.</li><li>A GP Partner had completed health coaching certification (for healthcare professionals) and was studying towards the British Society of Lifestyle Medicine Diploma, which promotes evidence-based lifestyle interventions.</li></ul>	

### Examples of continuous learning and improvement

#### Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-

scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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

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

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

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

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

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

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