

Care Quality Commission

Inspection Evidence Table

Braithwell Road Surgery (1-3910418013)

Inspection date: 29 and 30 September 2021

Date of data download: 27 September 2021

Overall rating: Good

We inspected the practice on 17 December 2018 when we rated the practice as requires improvement overall and for providing safe, effective and well led services and all population groups as requires improvement.

We followed up with an inspection in August 2019 when we found most areas requiring improvement had been addressed and the practice was rated as good for effective services. However, the practice remained as requires improvement overall and for providing safe and well led services because we were not assured all safety alerts had been received or actioned and the providers involvement in monitoring the service had been minimal.

When we inspected the practice on 29 and 30 September 2021, we found the practice had met the breach of regulations relating to safety alerts and had addressed most of the recommendations from the previous inspection. However, we found additional concerns as follows:

- The provider had not obtained information regarding conduct in previous employment prior to a member of staff commencing work at the practice.
- Information on staff vaccination status for non-clinical staff had not been obtained in line with the Department of Health Immunisation against infectious disease guidance (the Green Book).
- Not all the required reviews/monitoring checks had been completed for some prescribed medicines.
- Emergency medicines provision had not been risk assessed.
- Not all staff had completed the required training as per their training plan in the last 12 months.
- Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms were not always held on patient records and the decision had not always been reviewed.

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

Safe

Rating: Requires Improvement

At the inspection in August 2019 we rated the practice as **requires improvement** for providing safe services because we were not assured all safety alerts had been received or actioned.

At the inspection in September 2021 we rated the practice as **requires improvement** because whilst we saw improvement in the management of safety alerts additional concerns were found as follows:

- The provider had not obtained information regarding conduct in previous employment prior to a member of staff commencing work at the practice.
- Not all staff had completed the required training in the last 12 months.
- Information on staff vaccination status for non-clinical staff had not been obtained in line with the Department of Health Immunisation against infectious disease guidance (the Green Book).
- Not all the required reviews/monitoring checks had been completed for some prescribed medicines.
- Emergency medicines provision had not been risk assessed.
- Systems for receiving and acting on safety alerts had been strengthened and improved although we found evidence of one alert not being fully actioned for a small number of patients.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse but these were not always fully implemented.

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.	P
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:	
At the inspection in August 2019 we found appropriate level of DBS check specific to role had not always been obtained.	
At the inspection in September 2021 we found:	
<ul style="list-style-type: none"> • The practice had a register of vulnerable adults and children and all the records we reviewed had appropriate alerts to identify vulnerable patients. • The management team discussed safeguarding issues as required during their regular meetings. • Appropriate level of DBS checks specific to staff members role had been obtained. 	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> All but two members of staff had completed Adult or Child safeguarding training in the last 12 months. We were told this was due to staff availability during the pandemic impacting on time to complete training. Completion of training was addressed in appraisal and a training plan had been put in place where required. We were told staffing levels were now back to normal and protected time would be made available for staff to complete outstanding training. The lead GP told us they were working towards level 4 in safeguarding children. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>At the 2018 inspection the practice policy and procedure for recruitment had not been followed in respect of obtaining references and DBS checks for two staff prior to employment and a health assessment had not been completed. At the August 2019 inspection the references and DBS checks had been obtained for these staff. The practice manager had also taken action to ensure these were in place for all other staff. However, health assessments were not completed.</p> <p>At the inspection in 2021 we found two new members of staff had been employed and we reviewed their employment files. We found:</p> <ul style="list-style-type: none"> Practice policy and procedure for recruitment had not been followed because references had not been obtained for one non-clinical member of staff. We saw evidence a reference had been requested from the persons previous place of work in another GP practice but not been followed up. Health declarations were 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: December 2020	Y
There was a record of equipment calibration. Date of last calibration: 3 December 2020	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.	Y

Date of completion: February 2021	
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: At the inspection in September 2021 we found:	
<ul style="list-style-type: none"> The building is a large community leisure centre with this practice and another GP practice within the building. Maintenance of the fire systems within the building was undertaken by an external company arranged by the landlord. The practice manager told us the fire alarm was checked weekly and fire drills were arranged annually by this company. The records relating to these checks were held by the caretaker and were not available on the day of inspection. Not all staff had completed the required fire training in the last 12 months due to staff availability and plans were in place to ensure this would be addressed. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: April 2021	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: April 2021	Y
Explanation of any answers and additional evidence: At the inspection in September 2021 we found:	
<ul style="list-style-type: none"> The practice manager had completed certificated health and safety training and was scheduled for refresher training. We saw a risk assessment had been completed relating to processes in place to manage health and safety during the pandemic and to support vulnerable staff. 	

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: April 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>At the September 2021 inspection we found:</p> <ul style="list-style-type: none"> • A full audit had been completed by the lead nurse only minor issues had been identified and these had been addressed. This also included a hand washing audit. • Information on staff vaccination status for non-clinical staff had not been obtained in line with the Department of Health Immunisation against infectious disease guidance (the Green Book). • The IPC eLearning refresher training had been completed by most staff in the last 12 months. 	

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
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in 2018 reception staff responsible for care navigation had not had training relating to sepsis. However, at the August 2019 the appointment system had changed and all requests for appointments were now triaged by clinical staff and sepsis training had been provided to the nurses.</p> <p>At the September 2021 inspection we found:</p> <ul style="list-style-type: none"> • Sepsis awareness eLearning training had been made available to all staff and most staff had completed this in the last 12 months. Posters relating to signs and symptoms of sepsis were displayed in the practice and systems were in place to escalate any concerns about patients contacting the practice. Requests for appointments were triaged by the clinical staff. • There had been some impact on staffing levels during the pandemic due to individual circumstances. Staff had covered each other or had been enabled to work from home where this was appropriate. Risk assessments had been completed for staff working from home and return to work risk assessments had also been completed. 	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Systems were in place for urgent referrals to be processed the same day and for these to be monitored to ensure patients had been seen. 	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimization although these were not always fully implemented.

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)	0.83	0.77	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)	7.3%	6.7%	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	6.83	5.78	5.38	Tending towards variation (negative)

Indicator	Practice	CCG average	England average	England comparison
and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2021 to 30/06/2021) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	155.0‰	145.6‰	126.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	0.97	0.67	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	3.2‰	5.6‰	6.7‰	Tending towards variation (positive)

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

Any additional evidence or comments

Above average prescribing of hypnotics had been highlighted during the August 2019 inspection.

At the September 2021 inspection we found:

- There had been some improvement in the data for prescribing relating to urinary tract infections and, although still above local and national averages, this showed a continued downward trend over the last 12 months.

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.	P

Medicines management	Y/N/Partial
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.	P
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> <p>At the inspection in August 2019 we found the emergency drugs trolley could not be accessed by either the GP or the practice manager due to them being unable to remember the combination to the lock on the trolley. Data relating to prescribing for urine infections had not improved.</p> <p>At the inspection in September 2021 we found:</p> <ul style="list-style-type: none"> The emergency drugs trolley was accessible, and systems had been put in place to minimise the risk found at the last inspection. The trolley was well organised and contained most of the recommended emergency medicines which were checked regularly. Medicines such as a diuretic to assist patients with heart problems, intramuscular pain relief and a medicine to assist children with croup were not provided. A risk assessment had not been undertaken to direct the emergency medicines provision, however, the provider told us they had immediate access to an onsite pharmacy for additional medicines if required. They told us they would complete a risk assessment for this area. As part of our inspection, we undertook a remote search of the practice's clinical records system to review the monitoring of patients prescribed high risk medications. Although we found most patients received appropriate reviews for their condition and/or medication, we found some examples where a review had not been completed within the recommended timeframe or that not all the required monitoring checks had been completed or recorded. For example, we reviewed data for medicines used to treat auto-immune conditions – three patients were prescribed one of this type of medicine and none had had their weight recorded and one patient's records showed no blood tests completed in the last 11 months. Guidance states patients should have these checks completed at least three monthly after the initial dosing period. Evidence was provided after the inspection to show that the required bloods had been completed by clinicians in secondary care. Where 19 patients were prescribed another type of this medicine all had had the required monitoring checks completed 	

Medicines management	Y/N/Partial
<p>We reviewed data for medicines used to treat raised blood pressure and heart failure, 504 patients were prescribed this medicine in the last six months but 69 had not had the required monitoring checks. We looked at five of these patient records, all were over a year since the blood tests were last completed including one dating back to 2014. Guidance states patients should have their bloods checked at least annually. Following the inspection, the practice provided information to show that 16 of the 69 patients had a pending appointment or had been requested to attend an appointment.</p> <p>We reviewed data for medicines to reduce the risk of blood clots, 94 patients had been prescribed this medicine in the last six months. This showed all had had the required blood monitoring checks but 69 had not had a required calculation which informs dosage. We looked at five patient records and this had not been completed. The practice completed an immediate review of these patients and provided evidence they had since completed the calculation.</p> <ul style="list-style-type: none"> • The practice had the support of a Primary Care Network (PCN) funded pharmacist two days per week and pharmacy technician once a week. The practice also worked closely with the Clinical Commissioning Group (CCG) pharmacist. • We were told 99% of the patients were now on the electronic prescription service which has enabled the practice to track prescriptions sent to the pharmacy more effectively. 	

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:	2
Number of events that required action:	2
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had acted appropriately in respect of the individual incidents and a trend analysis was maintained. 	

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

Event	Specific action taken
Raised blood results for a patient taking a medicine to prevent blood clots.	The nurse discussed this with the GP and action was taken in respect of the medicine dosage.
Non-urgent referral not sent as expected.	GP noted the referral not been sent. Investigation undertaken and noted this was a communication error. Referral sent.

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:
 At the inspection in August 2019 we found the system for management of safety alerts was not robust and we were not assured all safety alerts had been received and acted upon.

At the September 2021 inspection we found:

- The practice had ensured they were receiving the required alerts and had put a system in place to manage the alerts and to ensure these were actioned appropriately. A log was maintained of alerts received and the action taken although it was not always clear from the records who had taken the required action. Alerts were saved to a shared drive and a hard copy was also kept so these were accessible to all staff. Systems were in place to ensure the alerts would be processed in the managers absence.
- We looked at three different medicines which had appeared in medicines safety alerts. We found one medicine used to treat depression where three patients over 65 years were prescribed higher than the recommended dose for patients of this age. Patient records did not evidence that the risks had been discussed with them.

Effective

Rating: Good

At the September 2021 inspection we rated the practice as **good** for providing effective services because:

- The practice had continued to provide an effective patient focused service during the pandemic despite the negative impact on staffing and had improved some areas such as childhood immunisations.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice used local and national guidelines such as Rotherham CCG guidelines and National Institute for Health and Care Excellence (NICE) guidance and they were able to access these electronically. Staff also used assessment and care templates within the electronic patient record system to ensure consistency and implementation of up to date guidance. All requests for appointments were triaged by clinical staff and systems were in place to escalate any concerns about patients contacting the practice. Systems were in place to manage and monitor urgent referrals. 	

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. A monthly multi-disciplinary meeting was held to discuss these patient's 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 medication 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.
- New patient health checks were provided.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Good

Findings

- 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.
- During the pandemic patients with chronic obstructive pulmonary disease (COPD) had their reviews completed over the phone due to these patients being at high risk, they were only asked to attend the practice for a blood pressure monitoring check. If the patient wanted to be seen or was experiencing problems, then they were invited in for a face to face appointment. Since April 2021 all patients have been invited in for their annual reviews. At the time of the inspection 33 of the 124 patients who had COPD had been seen for their annual review so far in 2021.
- During the pandemic patients with diabetes had been invited in for their monitoring checks and on receipt of the results the nurse discussed their results with them over the phone unless the patient wanted to be seen. All patients were now being invited in for their annual review and 97 of the 240 patients with diabetes had been seen since April 2021.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services.
- 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.
- Patients with asthma were offered an asthma management plan. During the pandemic asthma reviews were completed over the telephone unless the patient had concerns or wished to be seen face to face for a review. All patients had been invited in for a face to face appointment for their annual review. 55 of the 266 patients with asthma had been seen for their annual review since April 2021.

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)	76.3%	75.3%	76.6%	No statistical variation
PCA* rate (number of PCAs).	6.8% (19)	7.8%	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) <small>(QOF)</small>	93.0%	82.6%	89.4%	No statistical variation
PCA rate (number of PCAs).	3.7% (5)	7.1%	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) <small>(QOF)</small>	73.0%	79.2%	82.0%	Tending towards variation (negative)
PCA* rate (number of PCAs).	3.5% (4)	2.7%	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>	59.3%	58.8%	66.9%	No statistical variation
PCA rate (number of PCAs).	11.5% (16)	9.5%	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>	71.8%	70.1%	72.4%	No statistical variation
PCA rate (number of PCAs).	10.1% (57)	5.1%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) <small>(QOF)</small>	90.0%	92.0%	91.8%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	4.2%	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>	65.8%	69.4%	75.9%	No statistical variation
PCA rate (number of PCAs).	15.8% (22)	7.2%	10.4%	N/A

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

Families, children and young people

Population group rating: Good

Findings

- The practice had improved childhood immunisation rates since the last inspection and has now

met the minimum 90% for all of the five childhood immunisation uptake indicators. The practice has also met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four 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.
- 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.

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)	35	37	94.6%	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)	46	47	97.9%	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)	46	47	97.9%	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)	46	47	97.9%	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)	33	34	97.1%	Met 95% WHO based target

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 has improved childhood immunisation rates since the last inspection. Previously they were below the minimum 90% target in three areas.

Working age people (including those recently retired and students)

Population group rating: **Good**

Findings

- Patients had access to appropriate health assessments and checks. NHS checks for patients aged 40 to 74 had been contracted to another provider by the CCG but the practice offered health checks on request.
- There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery. The practice provided telephone triage by a clinician on request for an appointment to ensure the most appropriate service was provided.

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) <small>(Public Health England)</small>	78.8%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	79.7%	72.6%	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) <small>(PHE)</small>	62.7%	63.7%	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) <small>(QoF)</small>	100.0%	88.8%	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) <small>(PHE)</small>	54.5%	49.0%	54.2%	No statistical variation

Any additional evidence or comments

There is a slight improvement in cervical cancer screening uptake which was at 77.4% at the last inspection in August 2019.

The practice nurse had completed training to undertake samples for cervical screening. Patients who did not attend for cervical screening were followed up.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

At the inspection in August 2019 we rated this population group requires improvement because data showed the practice had only completed a very small number of care plan reviews for patients with a learning disability.

At the September 2021 inspection we found some improvement:

- There was some improvement in the number of care plan reviews completed for patients with a Learning Disability. They told us 10 of the 24 patients on their register had been seen so far although patients had not wanted to attend during the pandemic. We reviewed five records and found three had had a care plan review. They told us they had provided additional clinics in March 2021 to try and see as many patients possible for their annual review. They said they planned to provide the clinics again to try to improve engagement with this process. The practice told us they had been working with the learning disability nurse to improve the content of their reviews and had referred any patient who did not attend for their review to the learning disability team for support.
- Same day appointments and longer appointments were offered when required.
- End of life care was delivered in a coordinated way which considered 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.

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' services.
- During the pandemic the practice told us, due to the complexity of the patients with

dementia, these patients had always been offered face to face appointments as telephone reviews were not appropriate and eight of 18 patients on the register had had their annual review since April 2021.

- For those patients requiring mental health care plan reviews, these patients had been offered telephone or face to face appointments depending on their needs. They told us four of 20 patients on the register had been seen in 2021 for their annual review so far since April 2021.
- Same day and longer appointments were offered when required.
- 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.

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>	63.6%	80.3%	85.4%	No statistical variation
PCA* rate (number of PCAs).	0.0% (0)	10.5%	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>	90.0%	86.4%	81.4%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	6.3%	8.0%	N/A

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

Any additional evidence or comments

There had been a slight deterioration in performance in this area since 2018/2019 down from 93% for mental health reviews and 100% for dementia reviews however, the sample size was too small for this to be statistically significant.

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)	517.6	533.9
Overall QOF score (as a percentage of maximum)	92.6%	95.5%
Overall QOF PCA reporting (all domains)	5.6%	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

<p>The practice provided three prescribing audits completed since the last inspection.</p> <p>A two-cycle audit related to antibiotic treatment to prevent urinary tract infections showed there had been a reduction in prescribing of more than 30%.</p> <p>A two-cycle audit of prescribing for patients at risk of gastrointestinal adverse effects who are currently prescribed a nonselective nonsteroidal anti-inflammatory drug (NSAID) also showed improvement. For example, medication reviews had improved from 65% to 96%.</p> <p>An audit of anticoagulation prescribing for patients with prosthetic mechanical heart valves showed no improvement was required.</p>
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Effective staffing

The practice was able 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	Y

professional revalidation.	
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:	
At the September 2021 inspection we found:	
<ul style="list-style-type: none"> • Staff had accessed the eLearning programme but external training had been limited during the pandemic. Training such as fire safety, infection prevention and control and health and safety had been completed by most staff in the last 12 months. A central training matrix had been maintained. • We were told some training had not been completed in the last 12 months due to the impact of the pandemic on staff availability. However, a training plan for individual staff had been put in place where required and any issues with training completion were addressed through appraisals. Staffing levels had just returned to normal and the practice manager told us they were going to arrange protected time for staff to address outstanding training. 	

Coordinating care and treatment

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

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

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: <ul style="list-style-type: none"> • Patients were referred to external services, such as the Diabetes Prevention Programme, to support them to manage their long-term conditions. • Primary Care Network (PCN) funded social prescribers were also available to the practice and referrals to this service were made as required. 	

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.	P
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We reviewed five records relating to DNACPR decisions and found there was no DNACPR form in two cases and the decision had not been reviewed for another case. 	

Well-led

Rating: Good

At the August 2019 inspection we rated the practice as **requires improvement** for providing well-led services because management of safety alerts had been put in place we were not assured all alerts had been received or actioned and while there had been improvement overall the providers involvement in monitoring objectives were achieved had been minimal.

At the September 2021 inspection we rated the practice as **good** for providing well led services because:

- Processes relating to safety alerts had been reviewed and strengthened since the last inspection although we found evidence of one alert not being fully actioned for a small number of patients.
- Whilst there were still some improvements to be made there was improved management oversight and provider engagement in the running of the practice.
- The practice had continued to provide a patient focused service during the pandemic despite the negative impact on staffing and patient satisfaction with access and care and treatment had remained high.

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
<p>Explanation of any answers and additional evidence:</p> <p>At the August 2019 inspection we found most areas for improvement had been addressed. However, there was little evidence the provider had overseen the progress towards improvements required. However, the practice manager had been proactive in sourcing external support and training and acting on previous inspection findings.</p> <p>At the September 2021 inspection we found:</p> <ul style="list-style-type: none"> • There was improved oversight by the provider and weekly meetings were held between the manager and provider. Monthly summary records of the meetings were completed although these lacked details of attendees and any agreed actions. • The practice manager and the provider also now attended the monthly Primary Care Network (PCN) meetings. • The practice manager had been supported through the mentor system and worked closely with other managers in the PCN. • Staffing at the practice had remained stable but availability had been impacted by the pandemic. • Staff told us they felt supported. • The practice had continued to provide a patient focused service during the pandemic despite the impact on staffing and patient satisfaction with access and care and treatment had remained high. 	

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
<p>Explanation of any answers and additional evidence:</p> <p>At the August 2019 inspection we found most areas identified for improvement had been addressed although there was little evidence the provider had overseen this process.</p> <p>At the 2021 inspection we found:</p> <ul style="list-style-type: none"> • There was improved oversight by the provider and weekly meetings were held between the manager and provider and the manager felt supported. • The provider had a vision for the future which staff were aware of although not all felt they had been involved in the development of this. • The practice had continued to focus on provision of patient centred care. Data showed the practice had maintained good outcomes for patients and high levels of patient satisfaction. 	

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.	N
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found the practice had informed patients about duty of candour but had not developed a practice specific policy. The practice had a whistle-blowing policy and information about the freedom to speak up guardian but had not developed a practice specific policy. They had not identified a freedom to speak up guardian in relation to this policy.</p> <p>At the inspection in September 2021 we found:</p> <ul style="list-style-type: none"> • The staff handbook had been updated to inform staff who to contact for their freedom to speak up guardian. Staff told us they had been informed about how to contact the freedom to speak up guardian. The policy guided staff to report to the local freedom to speak up 	

- office, NHS England responsible officer with just an address but no name or phone number.
- A duty of candour policy had been developed but this had limited detail as to how this process should be implemented. The practice manager was able to inform us about the process they would take in these circumstances and said she would review the policy in this regard.

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

Source	Feedback
Staff questionnaires	Staff told us they were happy working at the practice and the atmosphere was good. They said they felt supported by the management and worked well as a team. They told us they had access to training and felt involved in the practice. They said all staff do their best for their patients and they received good feedback from patients.

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 August 2019 inspection we found the provider had no awareness they were not receiving safety alerts and there were no arrangements for any practice staff or the provider to receive alerts. At the September 2021 inspection we found:	
<ul style="list-style-type: none"> • Systems for receiving and acting on safety alerts had been improved and implemented although we found evidence of one alert not being fully actioned for a small number of patients. 	

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	Y

improved.	
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<p>At the August 2019 inspection we found some shortfalls in governance to manage safety alerts and it was not clear which alerts had been acted on.</p> <p>At the September 2021 inspection we found:</p> <ul style="list-style-type: none"> • Systems for receiving and acting on safety alerts had been implemented. • Systems to assess and minimise risk of Covid-19 had been implemented. Individual staff risk assessments had been completed and staff had been supported in arrangements to minimise risk such as working from home and a change to duties on return to work. 	

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	
<p>At the September 2021 inspection we found:</p> <ul style="list-style-type: none"> • Patient satisfaction with access to the practice appointments system was in line with or above local and national averages. 	

- During the pandemic the triage system, which was already in place for emergency on the day appointments, was extended to booking routine appointments. Triage of patients was undertaken by the advanced nurse practitioner or GP. Systems were in place for reception staff to raise any urgent concerns about a patient's health or wellbeing to the clinicians so they could be prioritised.

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 used information and data to check progress against targets and information from national surveys to assess patient satisfaction.	

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:

Information for patients about online services, data security and care records was displayed in the practice and on the practice website.

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.	N
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:

At the August 2019 inspection we recommended the practice review and improve patient engagement as the provider did not have a patient participation group (PPG) and the practice manager told us they had little interest from patients to form a PPG.

At the September 2021 inspection we found:

- The practice manager told us there was still little interest from patients for a PPG, a notice was displayed in the waiting room asking patients to become involved.
- The practice had installed a new IT system which enabled them to contact patients to send information leaflets and messages.
- The practice had a friends and family test (FFT) survey box in the waiting area where they collected handwritten feedback from patients and patients could also access FFT online. Data from the friends and family test (FFT) survey was all positive.
- The practice was also signed up to the online Rotherham health application (app). The Rotherham health app is a brand-new service providing online access for patients to manage their healthcare 24 hours a day, book appointments, check symptoms, manage medication, view test results and access their medical record. The app sent messages to patients asking about their experience at the practice. We observed all comments were positive.

Feedback from Patient Participation Group.

Feedback

No patient participation group.

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">• We found the practice manager and the nursing team had been encouraged to access external training and support relevant to their role and staff training had been encouraged and monitored. Whilst there had been an impact on staff training during the pandemic the practice manager had plans to address this.• The practice manager had been proactive in addressing areas identified for improvement at the last inspection.	

Examples of continuous learning and improvement
<ul style="list-style-type: none">• The practice had changed its approach to access to appointments during the pandemic and introduced total triage by clinicians.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **PHE:** Public Health England.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ***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.
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- ‰ = per thousand.