

# Care Quality Commission

## Inspection Evidence Table

**Dr R K Arora (1-583310398)**

**Inspection date: 23 September 2021**

**Date of data download: 15 September 2021**

## Overall rating: Good

At our previous inspection in January 2020 we rated the practice as Requires Improvement overall. We identified issues relating to the effective management and quality of care provided to patients due to staffing issues. This had impacted on the governance processes and the monitoring of clinical indicators. At this inspection we found that improvements had been made, clinical leadership and governance processes had been strengthened and systems had been implemented to improve the quality of care provided. We have now rated the practice as good overall.

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

## Safe

**Rating: Good**

### Safety systems and processes

**The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.**

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y

Safeguarding	Y/N/Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Staff we spoke with were aware of who they needed to go to if they had safeguarding concerns. There was a safeguarding lead in the practice and the local safeguarding team were based in the same health centre, so were easily accessible by the practice.</li> <li>• There were comprehensive policies and procedures for safeguarding children and vulnerable adults. These were reviewed and updated to reflect any changes and were accessible to staff.</li> <li>• Staff files reviewed demonstrated that Disclosure and Barring Service (DBS) checks were in place for staff as part of pre employment checks. This included enhanced and standard DBS checks based on the role and responsibilities of the job. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.</li> <li>• All staff had completed training relevant to their role. This included level three safeguarding training for clinical staff.</li> <li>• The practice had implemented a clinical decision support tool which worked in corrobation with the clinical system. The support tool was being used to identify children that may be at risk to ensure they received the appropriate follow up.</li> <li>• We reviewed five children's records on the safeguarding register and found the records contained safeguarding information from health visitors and school nurses. Safeguarding alerts and codes were seen on all the records we viewed, but we found only one record where a safeguarding alert was included on the record of the child's parent/carer. Following the remote review, we gained assurances from the provider that action was being taken to ensure that safeguarding alerts were included on the records of the parents of children with safeguarding concerns.</li> <li>• We also reviewed five adult safeguarding records during our remote review. We found safeguarding alerts and clear concise information on each record.</li> <li>• Multi-disciplinary team meetings were generally held every three months and Health Visitors attended the meetings. The meetings had not been as frequent during the COVID-19 pandemic, however meetings were now being organised and the most recent meeting had been held during September 2021.</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.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• At the previous inspection, the shortage of staff had impacted on the delivery of services. At this inspection we found the practice had recruited new staff members to strengthen the current team, these included GPs, a pharmacy technician, assistant practice manager and receptionists.</li> </ul>	

- We reviewed five personnel files for staff that had been recruited in the past 12 months. We found all the appropriate checks had been carried out prior to employment.
- An induction checklist was in place for each staff member tailored to their role.

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 26 March 2019	Y
There was a record of equipment calibration. Date of last calibration: 24 March 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. Date of completion: November 2020	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Evidence provided by the practice demonstrated that portable appliance and calibration testing had been organised for 27 September 2021.</li> <li>• Fire safety policies were in place and evidence was provided of a completed fire risk assessment. The last fire evacuation training took place in August 2021.</li> <li>• Monthly checklists were completed by the practice fire wardens to ensure extinguishers were easily accessible and not obstructed and fire escape routes were not obstructed.</li> </ul>	

<b>Health and safety</b>	<b>Y/N/Partial</b>
Premises/security risk assessment had been carried out. Date of last assessment: 20 January 2021	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 20 January 2021	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Health &amp; Safety actions had been acted on. For example: Unused boxes and folders that had been discarded by staff were left in the staff cloak room. All staff were informed of the process of disposal and the area was cleared of the hazards.</li> </ul>	

### **Infection prevention and control**

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

	<b>Y/N/Partial</b>
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.	Y
Date of last infection prevention and control audit:	
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• There was a contracted cleaning company in place to carry out the cleaning of the building. A cleaner was on site all day to follow up on any issues that were identified by the practice.</li> <li>• Spot checks were carried out by the management team and any concerns were highlighted to the onsite cleaner for action.</li> <li>• To ensure the safety of both staff and patients during the COVID-19 pandemic, clinical staff were given time between seeing each patient to clean their consulting rooms.</li> <li>• Staff had completed infection prevention training relevant to their role. There was an infection control lead in place.</li> <li>• Due to the COVID-19 pandemic, the practice had increased the frequency of cleaning, ensured there was adequate personal protective equipment available and carried out spot checks throughout the week to ensure control measures to minimise the spread of infection were being adhered to.</li> <li>• Policies, procedures and audit templates were in place for infection prevention and control and accessible for all staff.</li> <li>• We observed the general environment to be clean and tidy with the layout and facilities of the premises changed in line with COVID-19 guidance for infection prevention and control.</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.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Due to the COVID-19 pandemic the practice had reviewed their current staffing and had employed more staff to ensure there was adequate cover at all times. This included an increase in both clinical and non clinical roles.</li> <li>• The practice had been able to manage staff absences during the pandemic and had implemented new ways of working. This included training administration staff in various roles. This ensured that when staff were unable to work, other colleagues could carry on with their work in their absence.</li> </ul>	

## 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice had a system in place for the management of referrals under the two week wait process. A spreadsheet was in place to monitor all referrals that had been made to secondary care. Follow up of two week wait referrals were carried out to ensure these had been acted on by secondary care. Any issues identified by staff were referred to the GP for their review.</li> <li>We saw evidence of safety netting advice being given to patients who had been referred for a review in secondary care under the two week wait process.</li> <li>During the remote access of the clinical system we reviewed a random sample of patients records and found two week wait referrals had been made promptly and in accordance with best practice guidance.</li> <li>The practice had recently updated its system and processes for managing test results to ensure that appropriate action was taken when results were reviewed. A rota had been implemented for each GP with specific duties for them to complete during the day.</li> </ul>	

## Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.53	0.69	0.69	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). (01/07/2020 to 30/06/2021) (NHSBSA)	5.6%	6.8%	10.0%	Variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2021 to 30/06/2021) (NHSBSA)	6.07	5.17	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	109.4‰	132.0‰	126.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	1.37	0.69	0.65	Tending towards variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	7.4‰	8.5‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y

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.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• At the previous inspection, the practice were unable to demonstrate a structured approach to reduction of prescribing of hypnotic medicines. At this inspection we found that systems had been reviewed and strengthened to ensure the appropriate monitoring was in place.</li> <li>• Due to staff sickness, the practice had experienced difficulties within the administration team responsible for prescriptions. Due to the impact this was having on the monitoring of medicines, especially patients on high risk medicines, a pharmacy technician had been employed who had implemented a structured approach for the management of prescriptions and regular reviews of medicine usage.</li> <li>• There was clinical oversight for all requests for medicine changes and a clear process was in place to demonstrate what actions had been taken.</li> <li>• During our remote clinical review of patients on Methotrexate, we found the practice had not acted on a safety alert from 2020 which stated that the day the medicine should be taken was to be included on the prescription. We found a total of 19 patients were on this medicine and on reviewing five records there was no evidence to show that the day of the week on which Methotrexate was to be taken had been added to prescriptions.</li> <li>• Emergency medicines and vaccines were appropriately stored and there were clear monitoring processes in place.</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:	12
Number of events that required action:	12
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Staff were encouraged to report incidents to the management team. The practice had a record log of significant events and incidents that had occurred and the learning outcomes.</li> <li>• Significant events and the learning was shared with staff informally during the COVID-19 pandemic. The practice had recently restarted practice meetings. We were told these were going to be held on a monthly basis.</li> </ul>	

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

Event	Specific action taken
Handwritten request submitted by a community team for a specific medicine which had already been prescribed under a different name	<ul style="list-style-type: none"> <li>• Discussion with community teams to change how requests are submitted to avoid future errors</li> <li>• Electronic requests recommended to help prevent prescribing errors</li> <li>• Learning shared with prescribing team to ensure they are aware of the different names associated with certain medicines</li> </ul>
Vaccines left out of fridge comprising the effectiveness of the vaccine	<ul style="list-style-type: none"> <li>• Staff advise reception when a delivery is expected.</li> <li>• Once vaccines are delivered, staff responsible for vaccines must be notified so the vaccines can be stored correctly and without delay.</li> </ul>

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The practice had a system in place for the recording and acting on safety alerts. Evidence provided by the practice showed current alerts were disseminated amongst the appropriate staff for action and a log was kept by the management team.</li> <li>• We looked at a range of safety alerts and found the majority of these had been actioned appropriately. However, on reviewing a safety alert concerning the potential risks of two specific medicines combined, we found 35 patients on this combination. On reviewing a sample of five patients, we found these medicines continued to be prescribed and recent medication reviews had been carried out, but no changes had been implemented. We discussed our findings with the practice and have been assured that a review of each patient on this combination of medicines was being undertaken.</li> </ul>	



- Results from our clinical searches showed that the practice had not taken appropriate action on a safety alert for specific medicines which placed unborn children at risk if taken by mothers when pregnant. We found four patients on this medicine and evidence showed one patient had received advice on the risks related to pregnancy. Two patients were not under specialist review as recommended by the safety alert guidance and there was no record of annual pregnancy risk acknowledgement in any of the four records we viewed.

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## Effective

## Rating: Good

At the previous inspection we rated the practice as requires improvement for providing effective services. We found patient outcome data showed some patients with long term conditions and people with mental health had not received the appropriate reviews. At this inspection we have rated the practice as Good for providing effective services as the practice had implemented systems and processes to ensure care and treatment was delivered in line with evidence based guidance.

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• A range of monitoring templates had been devised and implemented to ensure patients treatment was regularly monitored.</li> <li>• Medication reviews were being carried out and on reviewing a sample of patients records we found them to be in line with recommended guidance.</li> <li>• An audit of clinical coding had been completed to ensure there was a uniform approach within the clinical team to identify patients conditions appropriately.</li> </ul>	

### Older people

### Population group rating: Good

#### Findings

- Clinical staff spoken with provided some examples of how they delivered effective care to older patients such as referring to social prescribers.
- 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.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medicines reviews for older patients.

- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

## People with long-term conditions

## Population group rating: Good

### Findings

- At the previous inspection we found the practice were unable to demonstrate some patients with long term conditions had received the appropriate monitoring. At this inspection we found systems had been implemented to effectively monitor patients' treatment. For example: Regular face to face COPD clinics were now being offered.
- Monitoring templates were now in place and evidence provided by the practice showed 17 patients had not received a COPD review in the past 12 months, however 15 patients had been invited for a review.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice had increased the nursing team and had provided further training for the health care assistant to perform diabetic foot checks. During the pandemic the education programme for new diagnosed diabetics was suspended. The practice had carried out a review of all patients who met this criteria and were in the process of contacting all patients to offer them a referral.
- 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 atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with asthma were offered an asthma management plan.

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)	66.4%	75.5%	76.6%	Tending towards variation (negative)
PCA* rate (number of PCAs).	2.8% (13)	6.7%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a	80.1%	88.4%	89.4%	No statistical variation

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)				
PCA rate (number of PCAs).	4.9% (8)	8.6%	12.7%	N/A

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

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	80.5%	80.6%	82.0%	No statistical variation
PCA* rate (number of PCAs).	6.4% (14)	3.9%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	68.5%	64.0%	66.9%	No statistical variation
PCA rate (number of PCAs).	18.2% (114)	11.8%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	75.7%	70.5%	72.4%	No statistical variation
PCA rate (number of PCAs).	4.4% (46)	5.6%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	94.2%	91.9%	91.8%	No statistical variation
PCA rate (number of PCAs).	4.7% (6)	3.7%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	70.8%	73.0%	75.9%	No statistical variation
PCA rate (number of PCAs).	8.6% (54)	8.4%	10.4%	N/A

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

### Any additional evidence or comments

The practice had seen improvements in QOF data since the last inspection for the annual review of asthma patients. Monitoring templates were now in place which highlighted patients that required a review. Invitations were sent out at regular intervals. Evidence provided showed that 54 patients had not had a review of their asthma plans in the previous 12 months, 51 patients had been contacted to attend an appointment.

**Findings**

- The practice had met the minimum 90% for all five childhood immunisation uptake indicators. The practice had not 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)	115	120	95.8%	Met 95% WHO based target
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)	97	106	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)	98	106	92.5%	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)	96	106	90.6%	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)	120	133	90.2%	Met 90% minimum

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

## Population group rating: Requires Improvement

Findings
<ul style="list-style-type: none"> <li>The practice had not met the target of 80% for cervical screening. Evidence provided by the practice showed 534 patients had been invited for a review in the past 12 months.</li> <li>The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.</li> <li>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.</li> <li>Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.</li> </ul>

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2021) (Public Health England)	74.7%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	74.1%	65.7%	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)	58.3%	54.9%	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)	87.1%	84.9%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	51.3%	48.0%	54.2%	No statistical variation

Any additional evidence or comments
The practice had reviewed and strengthened their processes for the invitation and recall of patients who were eligible for cervical smears.

**People whose circumstances make them vulnerable**

**Population group rating: Good**

**Findings**

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

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

**Population group rating: Good**

**Findings**

- At the previous inspection we found the practice were unable to demonstrate they had effective processes in place for the management of care plans for patients with mental health. At this inspection we found QOF improvements had been made and patients were reviewed on a regular basis.
- 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.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medicines.
- 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.
- 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>	85.5%	75.1%	85.4%	No statistical variation
PCA* rate (number of PCAs).	4.6% (4)	15.8%	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>	89.4%	66.7%	81.4%	No statistical variation
PCA rate (number of PCAs).	14.5% (8)	9.8%	8.0%	N/A

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

## Monitoring care and treatment

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

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	530.1	533.9
Overall QOF score (as a percentage of maximum)	94.8%	95.5%
Overall QOF PCA reporting (all domains)	5.4%	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

An audit was carried out to identify patients who had not been coded as diabetics following abnormal blood test results.  
The first audit was carried out in January 2020. The audit identified 36 patients with at least one abnormal HbA1c reading that had not been coded as diabetic. A review was carried out of each patient and a plan was implemented to ensure patients were monitored and reviewed regularly. The plan included the following:



- To ensure patients were invited for repeat blood tests.
- Diabetic nurse clinics were created that patients could book directly online.

A second audit was carried out in July 2021 which showed five patients who had not been coded appropriately. On reviewing each patient, a care plan was put in place. The practice plan to run the search on a six monthly basis to ensure that patients are being monitored effectively.

### Any additional evidence or comments

At the previous inspection we found the practice was unable to demonstrate a co-ordinated approach to reduce prescribing of hypnotic medicines. At this inspection we found the practice had carried out an audit to review hypnotic prescribing. In August 2021 a search of the clinical system was undertaken which identified 133 patients on hypnotic medicines that had not received a medicine review in the past 12 months. A review was completed for each patient to identify if patients had received a review, but had been clinically coded incorrectly or if the patient had not received the appropriate review. The practice found 55 patients required a follow up. This included the 47 patients who had not had a review in the past year and eight patients that required a further review. The remaining patients were either under secondary care or had received a medicine review which had not been coded appropriately.

To ensure reviews were carried out on a regular basis, the practice had employed a pharmacist and pharmacy technician to support the clinical team in the management of patients' medicine reviews. A programme of yearly monitoring was being implemented to monitor the prescribing of hypnotic medicines.

### Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• During the COVID-19 pandemic the practice had struggled with staff absence and a review was completed of staff roles to identify where a multi-task approach could be implemented. The review found that sharing duties amongst staff would provide continuity and maintain service</li> </ul>	

provision. Staff were trained in a variety of administrative roles to ensure staff absence caused no further impact on the services being provided.

- A system was in place to monitor and review staff training and we saw a high levels of completion rates for training specified as mandatory by the provider.
- Discussion with clinical and non-clinical staff demonstrated awareness and understanding in areas such as safeguarding and responding to an emergency.
- There was evidence of staff appraisals and staff reported they were encouraged and given opportunities to develop.

## 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The GPs met on an informal basis to discuss patients and to update each other on guidance. Monthly clinical meetings had stopped during the COVID-19 pandemic, but we were told these had just been restarted to ensure formal communication was in place.</li> <li>• Palliative care and safeguarding MDT meetings were held every three months to discuss patients on the palliative care register and those with safeguarding concerns.</li> </ul>	

## 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"> <li>• The practice had a programme of quality improvement to ensure clinical registers were up to date and patients received the appropriate reviews and monitoring. A range of templates were in place to monitor the effectiveness of the registers. For example: A COPD template had been implemented to ensure patients were invited and reviewed on a regular basis. This included the pharmacy technicians monitoring the prescribing of clinicians.</li> <li>• As part of the inspection we contacted one of the care homes for feedback. Care home staff told us they were well supported and had daily contact with the clinicians to discuss any concerns.</li> <li>• The practice had been allocated a social prescriber through their Primary Care Network. During the inspection we spoke with the social prescriber who told us the practice were pro-active in referring patients for support and guidance.</li> </ul>	

## 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

## Well-led

## Rating: Good

At the previous inspection we rated the practice as requires improvement for providing well led services as governance processes needed strengthening. At this inspection we have rated the practice as good for providing well led services as governance procedures had been embedded and the leadership team demonstrated skills to delivery quality care.

### 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>• Leaders understood the challenges impacting on the delivery of the service which included access to appointments and the impact of the COVID-19 pandemic. They had taken action to improve patients' experience which included the implementation of online appointments for specific conditions to reduce the difficulties in accessing the practice by telephone.</li><li>• Staff told us that leaders were approachable and supportive and staff engagement was encouraged.</li><li>• At the previous inspection we identified failings in the care of patients, this included: the lack of management of patients with some long term conditions and higher than average prescribing of hypnotic medicines. We carried out a remote review of a random sample of patients' records at this inspection and found improvements in patient care, effective processes for the management of patients with long term conditions and the appropriate monitoring of patients on hypnotic medicines.</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:

- The practice had a clear vision which was shared with staff through meetings and updates.
- Discussions with staff reflected the practice vision and values.
- Staff told us the aim was to deliver high quality care and promote good outcomes for patients. Improvements to services have been identified. For example: Ensuring communication was strengthened within the practice and patients were able to get an appointment when they needed one. Since the last inspection, the practice had prioritised the work that was required to ensure improvements were made to both quality and sustainability.

## Culture

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

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

Explanation of any answers and additional evidence:

- There was emphasis on staff wellbeing, and this was demonstrated through discussions with staff and evidence of appraisals.
- There was a policy for whistle blowing which allowed staff to understand the process and refer any concerns.
- Practice meetings took place which provided an opportunity for staff to discuss issues.
- Staff said they were confident to raise any concerns and felt they would be listened to.

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

Source	Feedback
Staff	We spoke with a range of staff during the inspection. Staff told us they were well supported, management were approachable and they worked together as a team.

## 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:	
<ul style="list-style-type: none"> <li>At the previous inspection we found the practice was unable to demonstrate fully developed and effective governance processes were in place. At this inspection we found the practice had carried out a review of their processes and had implemented and strengthened their governance structures. This included the recruitment of new staff to further enhance the current team. For example: A pharmacy technician was now employed to help support the GPs with medicine management.</li> <li>During this inspection, we found formal systems were in place to monitor the quality of services provided. The practice had implemented monitoring templates to ensure quality indicators were reviewed, risks were identified and there was a structured approach to support the governance arrangements.</li> <li>Policies and procedures were available on an electronic system which were accessible to all staff. Discussions with staff showed understanding and awareness of key policies such as safeguarding and whistleblowing.</li> <li>Discussions with staff and evidence reviewed from clinical records demonstrated patients care and treatment was delivered with effective governance structures and systems and with clinical oversight. On reviewing a random sample of patients' records we found patients' care and treatment was delivered in line with recommended guidance. Clinical oversight had been strengthened to ensure governance structures were regularly monitored.</li> </ul>	

**Managing risks, issues and performance**

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	

- The practice had a range of risk assessments in place, for example, fire, health and safety, and infection control.
- Since the previous inspection, the practice had fully embedded assurance systems. For example, on reviewing a sample of clinical records we found patients with long term conditions were being managed appropriately.
- There was a programme of clinical auditing in place to monitor quality and implement improvements. The programme was regularly reviewed and updated to ensure there was a formal analysis of quality and sustainability at the practice.

### 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• All patients that requested to see a GP were first given a telephone appointment. Following the telephone review, the GP would make a clinical decision if a face to face appointment was required.</li> <li>• All patients who attended the practice were asked a range of questions to ensure they had no symptoms in relation to COVID-19. Temperatures were taken, face masks were available if patients arrived without one and hand sanitizer was in place throughout the building.</li> <li>• Patients who were considered vulnerable had alerts on their clinical records to identify them.</li> <li>• Infection control processes had been strengthened and extra cleaning schedules had been implemented to ensure cleaning was carried out at frequent intervals. Clinical staff were given extra time between patients to clean their consultation rooms. Spot checks were in place to monitor guidelines were being adhered too.</li> <li>• COVID-19 risk assessments had been completed for each member of staff. Staff that were identified as higher risk were supported to work remotely.</li> <li>• Due to the size of the building where the practice was situated, vulnerable staff had the facilities to work socially distanced from their colleagues.</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:	
<ul style="list-style-type: none"> <li>• There were systems in place to monitor performance. A review of practice performance against the Quality Outcomes Framework (QOF) and the Primary Care Commissioning Framework (PCCF), a target driven programme of quality improvement implemented by the Clinical Commissioning Group was carried out on a regular basis.</li> <li>• Systems were in place to ensure risk assessments were completed on a regular basis to manage and mitigate risks. Action plans were in place to address any concerns identified.</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>• Online consultations took place in consultation rooms with the doors closed to protect the patients' privacy.</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>• Patients we spoke with told us that the social prescriber had been very supportive and called regularly to offer support.</li> <li>• The practice had faced challenges in recruiting to the patient participation group (PPG) and previous staff shortages had impacted on this in the past. The practice told us they had now established a PPG and planned to increase numbers through varying meeting times, venues and holding the meetings in a range of formats. For example: Online or face to face. The management team were working with the social prescribers to establish a diverse PPG.</li> </ul>	

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• At the previous inspection we found the practice was not utilizing care plan templates for patients with long term conditions and people with mental health and dementia. Following the inspection, the practice had implemented a clinical decision tool and a range of monitoring templates to identify patients that required a review. During our remote review of clinical records we found care plan templates were being used and detail mental health care plans were being produced and provided to patients at their mental health reviews.</li> <li>• During January to March 2021 the practice carried out an audit of the number of face to face appointments that were being offered. The audit led to the practice reviewing the types of conditions that a face to face appointment would be more appropriate for and a list of specific conditions was implemented for patients to be able to book face to face appointments directly. The list included skin issues and acute abdomen concerns.</li> <li>• The practice has a QOF action plan in place and was carrying out regular audits to improve patient care.</li> <li>• Two of the GPs at the practice had completed the GP trainer course and the practice had applied to become a GP training practice.</li> </ul>	

## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
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](#) ). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
- 
- $\text{‰}$  = per thousand.