

Care Quality Commission

Inspection Evidence Table

Brown Clee Medical Centre (1-591412896)

Inspection date: 16 August 2021

Date of data download: 16 August 2021

Overall rating: add overall rating here

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

Safe

Rating: Good

At our last inspection on 30 July 2019 we rated the practice requires improvement for providing safe services because:

- The management of safety systems and processes to keep people safe and safeguarded from abuse was not embedded. Not all staff had received training in safeguarding and the safeguarding policy was not local to the practice and did not reflect updated categories of abuse.
- Not all staff had received or were up to date with training in safe working practices.
- A basic environmental and health and safety risk assessment had been undertaken, however, an action plan had not been developed to identify the specific action to be taken, by whom and the date of completion. No fire risk assessment had been undertaken and fire notices displayed around the practice did not include the fire assembly point. There were no designated fire marshals appointed.
- Although the provider had considered the risk, at the time of the inspection there was no documented risk assessment for the security of medicines held in the dispensaries. A system to track prescription stationery and security of prescriptions throughout the main location had not been implemented. A controlled drugs cabinet or register was not available at the branch location for the storage of these medicines whilst awaiting collection. The controlled drug cabinet at the main location did not meet the required standard. A risk assessment had not been undertaken in relation to key holding responsibilities for dispensing staff. The controlled drug standing operating procedures (SOP) did not provide dispensing staff with clear guidance on the management and dispensing of these medicines. Medicines dispensed at the branch location were not being checked by a second person and dispensing labels were not being initialled by the dispenser.

At this inspection we found:

- The management of safety systems and processes to keep people safe and safeguarded from abuse had improved and all staff had received training in safeguarding. The safeguarding policy had been reviewed and updated and included all categories of abuse.
- All staff had received training in safe working practices. Risk assessments had been completed covering fire and safety, fire marshals had since been appointed and all staff had received training in fire safety.

- Improvements were noted in the management of medicines including controlled medicines (CD). However, the overall governance and oversight of their systems needed strengthening to assure quality.

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.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial
Staff who acted as chaperones were trained for their role.	Yes
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.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Staff we spoke with were aware of the practice safeguarding lead, were able to share examples of what would constitute a safeguarding concern and the action they would take if abuse was suspected or witnessed.</p> <p>At the last inspection we found not all staff had received training in safeguarding and the safeguarding policy was not local to the practice and did not reflect updated categories of abuse. At this inspection we found staff had access to safeguarding policies and procedures, which had been reviewed and updated and had received the appropriate level of training in accordance with their role.</p> <p>Staff told us they had the safeguarding App on their mobile devices in addition to their IT systems so they could readily access safeguarding information and contact telephone numbers.</p> <p>The practice did not hold routine meetings with the health visiting team due to changes within the health visiting team, however they were accessible by phone.</p>	

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.	No
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed the personnel files for two staff employed since the last inspection and found not all of the required checks had been obtained. For example, there was no satisfactory evidence of conduct in previous employment on one file we reviewed and there was no documentary evidence of any relevant qualifications on both files. A risk assessment had not been completed for a clinician while awaiting the outcome of a Disclosure and Barring Service (DBS) check despite having direct contact with patients. Following the inspection, the practice sent us a copy of references they had since obtained for one member of staff and evidence of their professional qualification.</p> <p>A health questionnaire was available on one of the two staff files we reviewed; however, there was no information available regarding staff immunisation status. There was no formal process for checking and recording this in addition for checking, recording and monitoring the registration status of clinical staff. Later during the inspection the practice provided evidence of the registration checks for the two clinicians whose records we reviewed.</p>	

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: 09/08/2021	Yes
There was a record of equipment calibration. Date of last calibration: 28/01/2021	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
A fire risk assessment had been completed. Date of completion: 14/08/2020	Yes
Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we identified some omissions concerning safety systems and records. For example, a fire and safety risk assessment had not been developed for the branch surgery, fire notices displayed failed to include the assembly point, no designated fire marshals had been appointed and not all staff had received fire safety training.</p> <p>At this inspection we found risk assessments had been completed covering fire and safety, fire marshals had since been appointed and all staff had received training in fire safety. Fire information was seen displayed in the waiting room and there was signage throughout the premises. Staff spoken with were aware of the assembly point. This information was added to the signage on the day of the inspection.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: July 2021	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: July 2021	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found a basic environmental and health and safety risk assessment had been undertaken. However, an action plan had not been developed to identify the specific action to be taken, by whom and the date of completion. We also identified that although the provider had considered the risk, no documented risk assessment for the security of medicines held in the dispensaries had been completed. At this inspection we found that the necessary health and safety risk assessments were in place and identified specific action to be taken.</p> <p>A legionella risk assessment was completed on the day of the inspection in addition to a risk assessment for the looped window blinds cords located in the waiting area and clinical areas, which can present a strangulation hazard to children and vulnerable adults. Agreed actions and timescales were documented.</p> <p>Staff we spoke with considered health and safety checks and awareness had improved since the last inspection. They told us safety checks took place on a weekly basis, including weekly tests of the fire system. They advised us a fire evacuation drill had taken place in July 2021.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met/not met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
<p>Infection prevention and control audits were carried out.</p> <p>Date of last infection prevention and control audit: Main location: 15/07/2021 Branch: 22/07/2021</p>	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Partial
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The Practice had arrangements in place to manage infection, prevention and control (IPC). Both premises were visibly clean and tidy on the day of the inspection.</p> <p>The practice had a designated IPC nurse lead who demonstrated a clear understanding of their role and responsibilities. Staff had access to the infection, prevention and control policy and personal protective equipment (PPE). Staff spoken with confirmed adequate supplies of PPE was readily available, including during the COVID-19 pandemic and that additional arrangements had been implemented to protect both patients attending the practice and staff safety in the workplace. At the previous inspection we found that some staff required refresher training in IPC. At this inspection staff we spoke with confirmed they had received this training, which was reflected on the training matrix that we saw.</p>	

IPC audits had recently been undertaken at both the main location and branch surgery. Required actions had been identified and documented but not always actioned with dates for completion. The IPC lead agreed to rectify this going forward in addition to implementing daily records for cleaning checks undertaken in accordance with the schedule.

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.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
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.	Yes
Explanation of any answers and additional evidence: Staff we spoke with told us the practice had systems in place for managing staff absences and that the team worked well covering for one another. For example, part-time workers picked up extra shifts to cover colleague absence when required.	

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

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) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.56	0.70	0.70	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). (01/04/2020 to 31/03/2021) (NHSBSA)	8.5%	8.3%	10.2%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2020 to 31/03/2021) (NHSBSA)	5.19	4.81	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	78.0‰	123.5‰	126.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	0.62	0.61	0.66	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	4.7‰	6.8‰	6.7‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Partial
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
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.	Yes
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.	Yes
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.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
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.	Partial
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection, we found omissions in relation to the management of Medicines. A system to track prescription stationery and security of prescriptions throughout the main location had not been implemented. A controlled drugs cabinet or register was not available at the branch location for the storage of these medicines whilst awaiting collection. The controlled drug cabinet at the main location did not meet the required standard. A risk assessment had not been undertaken in relation to key holding responsibilities for dispensing staff. The controlled drug standing operating procedures (SOP) did not provide dispensing staff with clear guidance on the management and dispensing of these</p>	

Medicines management	Y/N/Partial
<p>medicines. Medicines dispensed at the branch location were not being checked by a second person and dispensing labels were not being initialled by the dispenser.</p> <p>At this inspection we found some improvements in the management of medicines. Dispensary keys including CD keys were stored in a key safe in corridor within a staff only area. The access to the key safe area was currently not restricted. Dispensary staff stated the practice would be installing a Digilock on the door between the main corridor and staff only area. The key safe was observed to be locked on the day of the inspection. However, as the three CQC inspectors were leaving, it was seen to be wide open and unattended. When drawn to their attention, the practice manager closed the key safe. They were asked to remind colleagues to close and lock the key safe after its use.</p> <p>The blank paper prescriptions had been removed and destroyed at the main surgery at Ditton Priors. The Branch surgery at Stottesdon had two pads of paper prescriptions held securely in the Controlled drugs cupboard. The prescription numbers had been recorded in January 2021, but no further checks had been completed prior to the inspection. The practice intended to remove and destroy them as per guidance after discussion during the inspection.</p> <p>The Controlled drugs balance checks were being completed by the dispensary staff and recorded in the controlled drug register. They were then further recorded as being completed on a sheet of paper found on the back of the CD cupboard door. Once the sheet had been completed, it was removed and filed away in the dispensary. There were no external checks on the process to provide assurance of its completion.</p> <p>In the event of a medical emergency medicines were held and systems were in place to ensure these were checked on a weekly basis. The practice agreed to implement documentary evidence of these checks going forward.</p>	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Partial
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Yes
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Yes
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	N/A
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Yes
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	N/A
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	N/A

Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Yes
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Yes
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Yes
<p>Explanation of any answers and other comments on dispensary services:</p> <p>The dispensary processes checked during the inspection showed that they were being completed. However, discussion with staff indicated there was limited oversight. For example, the CD balance checks were being completed regularly, but the documents were not scrutinised for assurance purposes. There was also limited oversight and review of documents relating to other areas including medicine incident reporting and fridge temperature monitoring.</p>	

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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	17
Number of events that required action:	17
<p>Explanation of any answers and additional evidence:</p> <p>Staff spoken with confirmed they were comfortable raising concerns and reporting safety incidents and shared examples of the action taken, how information was shared and the learning. They considered improvements had been made to how incidents were raised, reported and learning shared across the team.</p>	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
A patient left an unlabelled urine sample in the bathroom	A poster had been placed in the bathroom reminding patients to complete a form to go with their sample prior to dropping it off at the reception. A recent audit of urine samples had been undertaken and the outcome was due to be shared with the team shortly and the policy updated accordingly.
A patient was given the wrong medication by the Branch dispensary.	The patient identified the error and contacted the Practice to alert them of the error. Learning points included ensuring all

	prescriptions were double checked and staff have sufficient time allocated for making prescriptions up.
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The remote clinical searches undertaken by the GP Specialist Advisor showed that the system for recording and acting on safety alerts was effective in identifying affected patients. Alerts were logged onto their computer system, where a message was sent out to relevant staff members to view and action the alert. The computer system allowed for an audit trail to be maintained outlining actions taken.</p>	

Effective

Rating: Good

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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none">• 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

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- 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) <small>(QOF)</small>	70.5%	74.1%	76.6%	No statistical variation
PCA* rate (number of PCAs).	0.4% (1)	13.3%	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>	83.9%	88.1%	89.4%	No statistical variation
PCA rate (number of PCAs).	3.4% (2)	14.0%	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
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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)	84.0%	79.0%	82.0%	No statistical variation
PCA* rate (number of PCAs).	2.4% (2)	4.8%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	51.0%	65.6%	66.9%	Tending towards variation (negative)
PCA rate (number of PCAs).	2.0% (3)	15.0%	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)	77.6%	69.2%	72.4%	No statistical variation
PCA rate (number of PCAs).	4.7% (20)	7.4%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	82.5%	90.3%	91.8%	Tending towards variation (negative)
PCA rate (number of PCAs).	5.9% (5)	4.7%	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)	77.4%	72.0%	75.9%	No statistical variation
PCA rate (number of PCAs).	1.4% (2)	10.0%	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 was aware of the slightly lower than average figures for diabetes. The practice had employed a new nurse, who had a qualification in the management of patients with diabetes. The practice had started to run specific clinics for managing the care of patients with diabetes. There was now a key person responsible for following-up on patients ensuring appropriate monitoring.

Findings

- The practice had met the minimum based target for all 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)	20	20	100.0%	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)	31	34	91.2%	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)	31	34	91.2%	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)	31	34	91.2%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	30	31	96.8%	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

A staff member we spoke with shared an example of the action they had taken when a child had not been brought to the practice for their scheduled immunisation. They had followed this up directly with the parent of the child concerned.

We were told the practice planned to undertake an audit of child immunisations shortly.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could order their repeat prescriptions online.

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)	76.6%	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)	82.0%	77.0%	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)	68.1%	66.6%	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)	87.9%	92.8%	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) (PHE)	62.5%	55.1%	54.2%	No statistical variation

Any additional evidence or comments

The Practice were aware they had not met the 80% target for women eligible for cervical screening. We were advised some patients chose not to attend the Practice for screening during Covid-19. The Practice told us they were in the process of undertaking an audit of women aged 50 to 64 who were eligible for screening in the first instance to help address the shortfall and then this would be extended to the younger group. A system was in place on the clinical system to flag non-attenders.

Patients had access to appointments with female sample-takers between 8am and 6pm at the main location Monday to Friday to encourage uptake.

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

- 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.
- The practice employed an in-house counsellor.

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>	90.0%	83.8%	85.4%	No statistical variation
PCA* rate (number of PCAs).	0.0% (0)	16.9%	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>	75.0%	79.1%	81.4%	No statistical variation
PCA rate (number of PCAs).	12.7% (7)	8.1%	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)	503.4	533.9
Overall QOF score (as a percentage of maximum)	90.1%	95.5%
Overall QOF PCA reporting (all domains)	2.1%	5.9%

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

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

At the last inspection we found that the clinical audits undertaken by the practice were limited and there was a lack of completed clinical audits undertaken to demonstrate quality improvement. Leaders fully acknowledged this at the time of the inspection and recognised the need to formalise audits and complete audit cycles. They told us they planned to review these at the next practice protected learning time.

At this inspection we found audits had been formalised and completed.

A clinician told us a recent audit had recently been undertaken on urine samples and the outcome was due to be shared across the team shortly. The Practice planned to undertake a cervical screening audit shortly.

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.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Partial
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.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Practice staff were allocated a time to complete any relevant training needed and they were sent reminders when training modules were due to expire. Staff told us they were offered payment if they had completed training in their own time. Staff spoke positively about the training opportunities provided and told us learning and development was discussed as part of their annual appraisal and ongoing work. A member of staff told us they had discussed a particular training course during their appraisal that they wished to pursue and were awaiting new course dates.</p> <p>At the last inspection we saw the practice had a new checklist in place for new staff to support them in their induction. The practice advised they provided a staff handbook that was used for medical students and would further develop the staff induction process based on this. However, at this inspection there was no documentary evidence available of staff induction on the two staff files we reviewed. We did see that the practice had supported new staff with professional learning and development opportunities.</p>	

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.	Yes

Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
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Helping patients to live healthier lives

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

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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>During the inspection we spoke with a member of the Patient Participation Group. With the patient's consent, they shared an example of how a new patient with an existing long-term condition, had been supported by the practice to understand their condition and manage their own health effectively.</p> <p>The practice had set up their own yoga group and had their own inhouse counsellor to support their patients. Patients could also access support through "healthier lives" group. Mediation was also available.</p>	

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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>A member of staff we spoke with was able to share examples of how they sought patient consent to care and treatment and how this was documented on the patient clinical records.</p> <p>We saw evidence that staff had received training in the Mental Capacity Act.</p>	

Well-led

Rating:Requires Improvement

At the last inspection we rated the practice as requires improvement for providing well-led services because:

- The provider had governance structures and systems in place however, these did not ensure effective governance. For example, at the time of the inspection there was a lack of oversight of the management of risks.
- Not all the information we requested was available on the day of the inspection. For example, information in relation to health and safety.
- The practice had a number of policies and procedures to govern activity. However, not all policies were readily accessible or reviewed and updated.

At this inspection we found:

- Structures, processes systems to support good governance and management had improved overall but were not always effective. For example there was no formal process in place for documenting the immunisation and registration checks of clinical staff. There were shortfalls identified in staff recruitment processes. There was also a lack of oversight in other areas including medicines management.
- Most information was available on the day of the inspection with the exception of information required by law to demonstrate safe staff recruitment processes.
- Policies and procedures had been reviewed, updated and were accessible to staff.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: At the last inspection we found leaders were visible, approachable and understood the strengths and challenges relating to the quality and future of services. They had identified the actions to address the challenges, for example the difficulties in recruiting GPs as part of succession planning but had not yet developed a documented succession or business plan. At this inspection we saw plans had been developed and discussed. Staff spoken with considered leaders were approachable and supportive in their work.	

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.	Yes

There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we saw the practice had a mission statement however, this was not displayed at either premise and was not readily accessible on the practice website. Staff we spoke with were not familiar with these values. Following the inspection, the provider told us they would make it more accessible on the practice website and would also display this on the information display screens in the waiting rooms. They also advised they had included the mission statement on all computer screens for staff. At this inspection staff told us they had access to and had been involved in reviewing and developing the mission statement for the Practice.</p> <p>This was:</p> <p>‘Our commitment is to the whole community. Working ethically and with compassion. We strive to provide quality healthcare, in a safe, trustworthy and accessible manner’. The Practice told us the mission statement was displayed on the overhead TV in the waiting room and staff had access to it on their desktops.</p> <p>The staff we spoke with understood their role and responsibilities in providing positive health outcomes for their patients.</p>	

Culture

The practice had a culture which drove high quality sustainable care

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we identified not all staff had completed training in equality and diversity. At this inspection the practice confirmed all but three staff had completed this training. Following the inspection we received confirmation that all but two staff, who were currently on leave, had since completed the training.</p>	

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

Source	Feedback
Staff	<p>Staff we spoke with reported that they enjoyed working at the practice and were supported in their work. They told us the practice had a good team structure in place. Two staff told us it was the best job they had ever had.</p> <p>Observations demonstrated a positive and inclusive working environment was promoted.</p>

Governance arrangements

The overall governance arrangements needed strengthening.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes

Explanation of any answers and additional evidence:

At the last inspection we found shortfalls in the practice's governance arrangements. Although governance structures and systems were in place, they did not ensure effective governance and there was a lack of oversight of the management of risks. Not all the information we requested was available for example, health and safety information. We also found not all policies were readily accessible or had been reviewed and updated.

At this inspection we found structures, processes systems to support good governance and management had improved overall but were not always effective. For example, there was no formal process in place for documenting the immunisation and registration checks of clinical staff to ensure these had been undertaken and regularly monitored. Shortfalls were also identified in staff recruitment processes to ensure staff were fit and safe to work. The dispensary processes checked during the inspection, showed that controlled drugs (CD) balance checks were being completed. However, discussion with staff indicated there was limited oversight. For example, the CD balance check documents were not scrutinised for assurance purposes. There was also limited oversight and review of documents relating to other areas including medicine incident reporting, fridge temperature monitoring and medicines in the event of a medical emergency.

Staff we spoke with confirmed practice meetings took place where information was shared and discussed, however they told us that they would welcome an increase in the frequency of these meetings held.

There were designated practice leads in place for key areas including infection control, safeguarding and IT. Staff spoken with demonstrated a clear understanding of their roles and responsibilities.

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.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes

Explanation of any answers and additional evidence:

At the last inspection, we identified concerns relating to the oversight and management of some issues relating to safety, and therefore the arrangements for identifying, managing and mitigating risks were not always effective. Within 48 hours of the inspection the provider sent us an action plan in response to the immediate concerns that we identified on the day of the inspection.

We also found only a limited number of clinical audits had been undertaken to include completed audits to demonstrate quality improvement. The need to formalise audits was fully acknowledged by the

practice to ensure a systematic programme of clinical audit was in place. Following the inspection, the practice told us they planned to review this at the next practice protected learning time. At this inspection, the practice shared seven of their audits with us.

At the last inspection the practice had a documented disaster and recovery plan in place, however this was dated 2008 and was therefore required review. At this inspection we found that the plan had been updated in July 2021.

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.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
Explanation of any answers and additional evidence: Staff told us they had been provided with Covid-19 training and that leaders had been very supportive	

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.	Yes
Performance information was used to hold staff and management to account.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence:	

At the last inspection we found not all the information we requested was available on the day of the inspection. For example, information in relation to health and safety. In addition the risk assessments we reviewed were limited, with no clear actions detailed or review. At this inspection we found improvements in the management of health and safety in the practice.

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.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence:	
The practice encouraged patients to leave feedback about the service through completing the Friends and Family Test (FFT). A suggestion box was also available in the waiting area. The Practice had a well-established Patient Participation Group, who were very active in representing the views of patients.	
The health care assistant (HCA) continued to provide a dual role within the practice. In addition to their HCA role, they worked part-time as a care co-ordinator (CCC). The CCC role included supporting and signposting patients to non-statutory, voluntary and independent organisations.	
Staff told us they were provided with regular opportunities to contribute to discussions and systems were in place to share information across the team. Staff we spoke with told us Practice meetings were held, however, some staff said they would welcome the opportunity for these meetings to be held more frequently.	

Feedback from Patient Participation Group (PPG).

Feedback
As part of the inspection we spoke with a representative of the PPG. They told us the group currently consisted of around 14 core members and that prior to the Covid-19 the PPG met with practice representatives four times a year. The group had a designated PPG notice board within the main location reception area and patients had access to minutes of the PPG meetings held. However, no face to face meetings had been held during the pandemic to ensure patient safety. They told us the PPG would like to recruit more new members to represent all patient population groups.
The representative told us the group had a very good relationship with the practice staff and they were kept well informed of any developments within the practice. They said the practice listened intently to the views of the PPG and always acted on them.
The representative told us they had set up a Facebook social media page for the Practice and currently had 507 members. During the pandemic patients were raising numerous questions on the page regarding covid-19. As a result the representative shared these questions with the GPs and three video presentations

were made by the practice and shared on the page to ensure patient questions were answered and patients reassured. They also told us through the Facebook page they had gained patient feedback from patients about their views and experience about the practice and about remote consultations. Patients could share their experiences via a private messaging system and with patient consent examples were shared with us. Feedback about patient experiences regarding the care and treatment they had received was very positive.

The representative also advised that 20 patients from the Practice volunteered to assist with the local Covid-19 vaccination programme, for example site marshalling.

The representative told us the findings of the last CQC inspection report was shared and discussed with the PPG. A GP attended a PPG meeting and told them of what the Practice had done to address the shortfalls identified.

Any additional evidence

We reviewed the outcome of the national GP patient survey 2021 results for the practice. Results showed the Practice continued to have very high patient satisfaction levels with the Practice achieving significantly higher results across all areas compared to local and national averages. For example, 99% of respondents responded positively to their overall experience of this GP practice compared with the local average of 84% and the national average of 83%. Results also showed 100% of respondents responded positively to how easy it was to get through to the Practice on the phone compared with the national average of 67%.

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.	Yes
Learning was shared effectively and used to make improvements.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The provider was committed to continuous learning and improvement. They were involvement in projects within the local community and an active members of the local Primary Care Network. Improvement were noted in the process of clinical auditing since our last inspection.</p> <p>Year on year, the practice was consistently rated very highly in the National GP surveys, demonstrating high rates of patient satisfaction.</p>	

Examples of continuous learning and improvement

Since the last inspection, the practice had implemented the electronic prescribing system (EPS).

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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