

# Care Quality Commission

## Inspection Evidence Table

### Alveley Medical Practice (1-569481539)

Inspection date: 4 July 2019

Date of data download: 28 June 2019

## Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

## Safe

## Rating: Good

At our previous inspection on 28 February 2018, we rated the practice as requires improvement for providing safe services. This was because:

- Some medicines dispensed in packs/trays included tablets surrounded by the foil blister packaging.
- Patient safety alert systems did not include evidence of the actions the practice had taken.
- Improvements were required in respect of patient group directions and fridge temperature monitoring.

At this inspection, we found that the provider had satisfactorily addressed these areas.

### 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 took account of patients accessing any online services.	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.	Yes

Safeguarding	Y/N/Partial
Staff who acted as chaperones were trained for their role.	No
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 demonstrated a clear understanding of what would constitute a safeguarding concern and the action they would take if abuse was suspected or witnessed. Staff knew who the safeguarding lead was for the practice and had access to the contact details of external agencies. Vulnerable patients were discussed at clinical meetings held. Clinicians we spoke shared examples of reporting safeguarding concerns and the actions taken. A GP partner told us that being a small practice meant the team knew all children at risk and families well and monitored them closely during regular reviews, and routine immunisation. There were systems in place to monitor and follow up when children had not been taken to appointments following referral to secondary care and immunisations.</p> <p>All staff had completed level two safeguarding adults and level three safeguarding children training, except for a receptionist who had completed level one safeguarding adults training and was due to complete level two shortly.</p> <p>Only the clinical staff provided a chaperone service, however they had not received training.</p> <p>The practice advised that the health visitor no longer visited the practice to discuss children of concern. However, the GP we spoke with shared an example of how they had worked together with the health visitor concerning a young child.</p> <p>Regular multi-disciplinary meetings were held to discuss adult patients at risk and minutes of meetings were maintained.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Applicants were asked during interviews held about any physical or health conditions which were relevant to the position they were applying for and outcomes were documented in interview records. Going forward the practice advised they would request appointed personnel to complete a questionnaire relating to any relevant health conditions.</p>	

<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: 1 July 2018	Yes
There was a record of equipment calibration. Date of last calibration: 3 July 2019	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
There was a record of fire extinguisher checks. Date of last check: July 2018. Next checks planned to take place shortly.	Yes
There was a log of fire drills. Date of last drill: 13 June 2019	Yes
There was a record of fire alarm checks. Date of last check: 4 July 2019	Yes
There was a record of fire training for staff. Date of last training: Various – all completed in 2019.	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 21 February 2018	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: A legionella risk assessment had been carried out on 11 September 2018 by an external contractor. Recommendations made had been met. Two staff had received fire marshal training. However, there was no high visibility safety vest available. The practice advised they would action this and immediately following the inspection they sent us information that confirmed a high visibility safety vest had been ordered. Actions from the fire risk assessment had been completed but dates of completion had not been recorded. The practice advised they would action this.	

<b>Health and safety</b>	<b>Y/N/Partial</b>
Premises/security risk assessment had been carried out. Date of last assessment: January 2019	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: January 2019	Yes
Explanation of any answers and additional evidence: The practice completed monthly health and safety checks and findings were recorded. These included	

checks on the practice fire protection, water systems, internal and external aspects of the building, privacy curtains, accidents and incidents, risk assessments, staff training and infection prevention and control.

## Infection prevention and control

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

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 1 March 2019	Yes
The practice had acted on any issues identified in infection prevention and control (IPC) audits.	N/A
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 was visibly clean and tidy on the day of the inspection. Feedback we gained from patients suggested they were satisfied with the cleanliness of the practice and the hygiene measures in place.</p> <p>The practice had a comprehensive infection control policy in place, which included names and contact details of IPC lead members from the clinical commissioning group (CCG) should staff required advice. The designated lead had very recently changed; however, this had not been reviewed and updated in the policy. Following the inspection, the provider sent us an updated version of the policy that reflected the change. The lead advised us they would be attending additional IPC training to support them in their new role as lead. One receptionist had not received infection, prevention and control training except for a discussion with the former IPC lead during their induction.</p> <p>No issues had been identified in the most recent infection prevention and control audit carried out in March 2019. The practice employed their own cleaner two evenings per week and cleaning schedules were in place and maintained. The practice manager completed periodic spot checks on the cleanliness of the practice and records reviewed showed two spot checks had been undertaken in 2019.</p> <p>Since the last inspection carpets in all clinical areas had been replaced with a smooth, slip resistant and easily cleanable floorcovering.</p>	

## 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
Comprehensive risk assessments were carried out for patients.	Yes

Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	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
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Clinicians we spoke with demonstrated an awareness of sepsis guidelines and had the equipment needed for diagnosis. We saw information about sepsis and associated symptoms was displayed throughout the practice and had been discussed at a clinical meeting held following a sepsis course attended by one of the GPs. If sepsis was suspected, blood tests were undertaken, and the results obtained the same day to ensure appropriate antibiotic prescribing. Receptionists we spoke with were aware of actions to take if they encountered a deteriorating or acutely unwell patient.</p>	

## 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
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented 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
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes
Explanation of any answers and additional evidence: Only members of the clinical team reviewed patient test results.	

## 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) (01/04/2018 to 31/03/2019) <small>(NHS Business Service Authority - NHSBSA)</small>	0.92	0.89	0.88	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). (01/04/2018 to 31/03/2019) <small>(NHSBSA)</small>	8.9%	8.1%	8.7%	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 (01/10/2018 to 31/03/2019) <small>(NHSBSA)</small>	5.76	5.69	5.61	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) <small>(NHSBSA)</small>	0.81	2.03	2.07	Variation (positive)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Yes
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	Yes



Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
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.	Yes
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.	No
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>The practice employed a pharmacist for two sessions per month.</p> <p>The average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) was significantly lower than local and national averages.</p> <p>The average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) <sup>(NHSBSA)</sup> was significantly lower than the local and national averages.</p> <p>The practice had the suggested emergency medicines available except for opiates. A risk assessment had not been completed to assess the risks associated with not having this medicine available.</p> <p>At our previous inspection in February 2018, we found improvements were required in respect of patient group directions and fridge temperature monitoring. We had previously found two of the Patient Group Directions (PGDs) were out of date. The practice had since actioned this and undertook a significant event analysis and review of all the paper copies of the PGDs to ensure they were the most current, that all had been signed off by the GP, read, and signed by the nursing staff. During this inspection we did not identify any further concerns in relation to PGDs. Following the last inspection staff had received refresher training to ensure they understood the checks required to maintain fridge temperature ranges and the provider had purchased two 24-hour fridge data loggers to enable a failsafe system.</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.	Yes
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
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.	Yes
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.	Yes
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 practice was a dispensing practice for over 99% of its registered population in their rural community. Since the last inspection the dispensing staff had moved into a new dispensary within the practice. This provided dispensing staff with additional workspace. Dispensing staff were very happy with their new working environment.</p> <p>At our previous inspection in February 2018, we found that a patient's medicine dispensed in a tray had been surrounded by the foil blister packaging. At the time of the previous inspection there had been a recent patient safety alert issued in this regard of which the dispensary staff were unaware. This risk had been mitigated by the fact that the patient's family member was the only person who administered the medicine, which was known by the dispensing staff. However, there was no documented risk assessment in place. At this inspection we saw risk assessments had been carried out in relation to this patient and a further two patients who resided at a local care home. The risk had been mitigated as all three patients were being supported and supervised with the administration of their medicine dispensed in a tray surrounded by the foil blister packaging.</p> <p>One GP provided advice to other local dispensing GP practices.</p> <p>The practice continued to have arrangements in place to ensure a patient received the medicine they required due to their allergies which required sourcing from another country.</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 since the last inspection:	32
Number of events that required action:	32
Explanation of any answers and additional evidence: Leaders promoted a culture of reporting and recording all incidents including near misses as significant events. Staff had access to a significant event recording template. This included a summary of the event, analysis, comments, action plan and follow up and the date the information was shared with the team. Significant events were shared at meetings held. A record of all significant events was maintained, and an analysis was undertaken to identify any common trends and learning points. Common trends identified were mainly in relation to dispensing errors, which were mainly identified before they were dispensed. This had been discussed with partners and a meeting held with the dispensing team. Significant events were a standing agenda item at staff meetings held.	

### Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Cold chain incident due to a power failure lasting 23 hours.	The practice followed their cold chain incident reporting procedure and contacted the fridge company and vaccine manufacturers for advice. A clinical decision was made to remove and dispose of all vaccines affected. Public Health England were notified, and a cold chain incident reporting form completed as requested.
A swab was sent in error on another patient of the same name and address.	The practice staff identified the error when the results came back from the laboratory. Computer records were amended, and a same name alert entered on both patients' notes. The hospital was informed and requested to resend results on the correct patient. The patient did not come to harm.

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
Explanation of any answers and additional evidence:	

At our previous inspection in February 2018, we found the patient safety alert system did not include documentary evidence of actions the practice had taken in response to the alerts and there was no archive of patient safety alert records they could reference. Immediately following the inspection, the practice acted on the feedback they had received and demonstrated how alerts would now be documented, reviewed actioned and archived for ease of reference and patient safety. At this inspection we saw the practice now used TeamNet, a web-based platform for sharing, exchanging and collaborating in primary care groups to distribute the alerts received via the central alerting system. Alerts were reviewed to see if they were relevant to general practice, distributed and searches undertaken to identify patients affected. We saw examples of actions taken on recent alerts for example, regarding sodium valproate. No patients of child bearing age were identified.

## 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
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) <small>(NHSBSA)</small>	0.20	0.76	0.77	Significant Variation (positive)

## Older people

## Population group rating: Good

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age. 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. Double appointments were also available.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Clinicians 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. The practice provided patients with 24-hour blood pressure monitoring equipment and trained them in their use for those clinically assessed as requiring them.
- 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.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	86.3%	81.2%	78.8%	No statistical variation
Exception rate (number of exceptions).	1.6% (3)	12.5%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	84.9%	76.7%	77.7%	No statistical variation
Exception rate (number of exceptions).	3.8% (7)	9.9%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	91.9%	80.1%	80.1%	Variation (positive)
Exception rate (number of exceptions).	7.5% (14)	13.2%	13.5%	N/A

Other 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, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) <small>(QOF)</small>	75.5%	75.8%	76.0%	No statistical variation
Exception rate (number of exceptions).	1.3% (2)	6.9%	7.7%	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 (01/04/2017 to 31/03/2018) <small>(QOF)</small>	94.5%	90.7%	89.7%	No statistical variation
Exception rate (number of exceptions).	1.8% (1)	12.1%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	89.2%	82.4%	82.6%	Tending towards variation (positive)
Exception rate (number of exceptions).	1.9% (10)	4.5%	4.2%	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 (01/04/2017 to 31/03/2018) <small>(QOF)</small>	94.8%	88.5%	90.0%	No statistical variation
Exception rate (number of exceptions).	4.9% (4)	7.0%	6.7%	N/A

## Families, children and young people

## Population group rating: Good

### Findings

- Childhood immunisation uptake rates were above the World Health Organisation (WHO) targets.
- 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)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) <small>(NHS England)</small>	14	14	100.0%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) <small>(NHS England)</small>	15	15	100.0%	Met 95% WHO based target (significant variation positive)
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) (01/04/2017 to 31/03/2018) <small>(NHS England)</small>	15	15	100.0%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) <small>(NHS England)</small>	14	15	93.3%	Met 90% minimum (no variation)

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

Childhood immunisation uptake rates were significantly higher than the World Health Organisation (WHO) targets in three of the four indicators.

### 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 book or cancel appointments online and order repeat medication without the need to attend the surgery.

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) (01/04/2017 to 31/03/2018) (Public Health England)	79.2%	76.7%	71.7%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	79.6%	78.1%	69.9%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	64.6%	61.5%	54.4%	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. (01/04/2017 to 31/03/2018) (PHE)	94.4%	72.9%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	66.7%	49.8%	51.9%	No statistical variation

#### Any additional evidence or comments

An annual audit of female patients who had cervical cancer screening carried out in 2018 had been undertaken by a practice nurse. Features searched for included the number of smears performed in 2018, who performed the smear and how many were inadequate smear results. Of the 108 smear samples taken, no inadequate smears were found.

#### People whose circumstances make them vulnerable

Population group rating: **Good**

#### Findings

- Same day appointments and longer appointments were offered when required.
- The practice had 10 patients with a learning disability on their register. All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

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

**Population group rating: Good**

**Findings**

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- 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 (01/04/2017 to 31/03/2018) <small>(QOF)</small>	92.9%	92.4%	89.5%	No statistical variation
Exception rate (number of exceptions).	17.6% (3)	11.9%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	100.0%	90.2%	90.0%	Variation (positive)
Exception rate (number of exceptions).	5.9% (1)	10.1%	10.5%	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 (01/04/2017 to 31/03/2018) <small>(QOF)</small>	78.3%	85.1%	83.0%	No statistical variation
Exception rate (number of exceptions).	6.1% (3)	5.9%	6.6%	N/A

## 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	CCG average	England average
Overall QOF score (out of maximum 559)	559.0	548.8	537.5
Overall QOF score (as a percentage of maximum)	100.0%	98.2%	96.2%
Overall QOF exception reporting (all domains)	3.9%	5.2%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Yes
Quality improvement activity was targeted at the areas where there were concerns.	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

Clinicians had carried out a range of audits since the last inspection. These included audits on high risk drug monitoring, NOAC anticoagulant (blood thinning medicines) audit, warfarin, asthma, ear wax removal, spirometry, ring pessaries fitted and complications rates, cervical cancer screening, warfarin and a deep vein thrombosis (DVT) prevention audit.

The DVT audit was carried out to see how the practice was performing against current good practice guidelines compared to the previous year. The practice carried out a search on patient records for terms including DVT or deep vein thrombosis and included any patients with suspected DVT. For each patient the practice compared their management with current standards set by NICE guidelines and assessed the probability of DVT against a set scoring system (Well's) to identify the risk. Fourteen patients were identified. The outcome was that the practice was treating all positive DVTs well but were not meeting standards across all areas compared to the previous year. Some of the identified factors were not controlled by the practice. For example, hospital waiting times resulting in scans not being achieved within 24 hours. Other criteria which was not externally influenced was detailed in the audit and recommendations documented including ensuring the Well's score was recorded in patient records for those with suspected DVT in addition to introducing prompts in the clinical system or a flow-chart on the management of suspected DVTs to assist staff.

#### **Any additional evidence or comments**

The practice had achieved an overall QOF score of 100.0% in 2017/18. QOF is a system intended to improve the quality of general practice and reward good practice. This score was above the local and national averages with a lower exception reporting rate across all clinical indicators was significantly lower than local and national averages meaning more patients were included. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.

The practice had a designated GP lead for monitoring the practice performance.

## 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. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Yes
The learning and development needs of staff were assessed.	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.	Yes
Induction included completion of the Care Certificate for Health Care Assistants (HCA's) employed since April 2015.	N/A
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.	N/A
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<b>Any additional evidence or comments</b>	
The practice did not employ health care assistants or nursing staff involved in advanced clinical practice. The nurses were not prescribers.	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
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	Yes

services.	
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes
<b>Any additional evidence or comments</b>	
Staff had received training in active signposting. The practice manager told us they had organised training for all reception staff across the Hub. Staff had access to a signposting page on their desktops which included contact details for the local authority community services, the clinical commissioning group, the community and care co-ordinators working across the hub and other groups to include the Samaritans. An active signposting forum had been set up for staff to add local services.	
The practice up until recently had a community care and co-ordinator (CCC) based at the practice. They had assisted in signposting patients to relevant local support services.	

## 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.	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, tackling obesity.	Yes

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	98.1%	95.0%	95.1%	Tending towards variation (positive)
Exception rate (number of exceptions).	0.4% (3)	0.7%	0.8%	N/A

## 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
The practice monitored the process for seeking consent appropriately.	Yes
Policies for any online services offered were in line with national guidance.	Yes
<b>Any additional evidence or comments</b>	
Staff had received training in the mental capacity act including non-clinical staff.	



## Well-led

Rating: Good

### 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.	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: We found there was compassionate, inclusive and effective leadership. Leaders were visible and approachable and understood the strengths and challenges of the services provided. Responsibilities were equally shared between the GP partners.	

### 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
Explanation of any answers and additional evidence: The practice had a detailed set of aims and objectives which were detailed in their statement of purpose and made available to patients in the reception area. These included: <ul style="list-style-type: none"><li>• Ensuring high quality, safe and effective services for patients.</li><li>• Providing healthcare which is available to a whole population and creating a partnership between patient and health professions which ensures mutual respect, holistic care and continuous learning and training.</li></ul>	

## 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.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a well-established team led by leaders who promoted an open culture of reporting and sharing communication practice wide. Significant events, complaints and compliments were shared across the team to improve the future delivery of the service and patient experiences. The practice considered their staff and treated them fairly and considered equality. There was an inclusive culture.</p> <p>Staff had access to a whistleblowing policy. Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. Openness, honesty and transparency were demonstrated when responding to incidents that had occurred in the practice.</p>	

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

Source	Feedback
Staff discussions	Staff we spoke with described positive working relationships within the team. They told us they enjoyed their work and felt very much supported by the GPs and the management team. Staff we spoke with told us they felt respected, supported and valued and were proud to work at the practice.

## 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.	Yes
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: Staff we spoke with commented positively on the sharing of information and the general communication within the practice. Regular meetings were held with staff to enable the effective sharing of information and ensure all staff were kept up-to-date with any changes. The range of internal and external meetings included: clinical, partner, whole team meetings, dispensary staff meetings, patient participation meetings and palliative care meetings. Meetings were recorded.  Practice policies, protocols and best practice guidance documents were accessible to support and guide staff in their work. Training was arranged according to the staff skill set and professional requirements.  Leaders had key roles. These included a Caldicott guardian lead, safeguarding lead and information governance lead. An external data protection officer had been appointed and staff were aware of their role and responsibilities in relation to protecting personal data.  Staff had access to a range of policies and procedures to support and guide them in their work. These were easily accessible to staff and were regularly reviewed and updated.	

## 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 systematic programme of clinical and internal audit.	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:	
A range of audits had been carried out demonstrating the actions taken to improve quality and outcomes for patients.	

## 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 adjust and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	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:	
Data to include Quality and Outcomes Framework (QOF) was regularly monitored, shared and discussed in staff meetings to drive improvements in quality and sustainability.	
Staff had received annual appraisals and told us they had opportunities to discuss their personal training and career development plans.	
Staff respected patient confidentiality. Many staff told us they lived locally and were required to read and sign a confidentiality declaration.	

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Any unusual access was identified and followed up.	Yes

## 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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had an established patient participation group (PPG) and involved patients in decisions about the service and delivery of care provided.</p> <p>Staff we spoke with told us the GPs and the practice manager actively encouraged them to contribute ideas and suggestions for improvements. They attended regular meetings and had opportunity to add to the meeting agenda.</p> <p>The practice told us they were proud of their partnership working with other professional services within the community. A range of independent practitioners were available for patients to be seen by appointment including Age Concern, Shropshire Housing, chiropody service, community district nurses, counselling service and the memory café.</p>	

### Feedback from Patient Participation Group (PPG).

Feedback
During the inspection we met with three members of the PPG. They told us they met with the practice on a quarterly basis and the membership generally consisted of six core members and this was increasing. They told us they really valued the practice, felt their views were listened to and continued to have good working relationships with the practice. The PPG had a designated notice board in the waiting room.

### Other feedback

CQC comments cards	
Total comments cards received.	12
Number of CQC comments received which were positive about the service.	12
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Patient discussions	During the inspection we spoke with six patients. Feedback overall was very positive about the care and treatment they received. Patients said that they felt the practice cared about their health and gave them support to improve their wellbeing.

CQC comment cards	Patients shared positive experiences about the care and treatment that they received from the practice. Many commented on the professionalism of all clinical and non-clinical staff who they had found to be friendly, very caring, kind and compassionate.
Care Home	We spoke with the manager from a local residential home. Feedback was very positive in relation to the service their patients received. They told us the clinicians were responsive to the health needs of their residents and they had developed positive working relationships with the practice.
Healthwatch Shropshire	Healthwatch Shropshire advised us they had received three comments since 2017. Two were positive and one was negative. One patient commented on the outstanding service they had received and the attention to detail, another patient commented that the practice was good at prioritising children. The negative comment was in relation to the difficulties experienced with a prescription.
NHS website	The practice had a rating of one star out of five stars based on one rating. The review, posted on 3/04/2018, related to difficulties with obtaining an appointment.
National GP Patient Survey – published 08/2018	The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice was in line with the local average and higher than the national average.  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 was significantly higher than the national average. Practice: 97% compared to the national average of 70%.

### Any additional evidence

The practice used a range of formats available to gain patient views and experiences. These included the national GP survey, the friends and family test (FFT), complaints and compliments. Feedback was shared with staff to help improve services.

### 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
Explanation of any answers and additional evidence:	
The practice was training practice and were committed to the continuing training of their foundation doctors, whom they closely supervise. Foundation doctors offered appointments with patients two days a week. To date the practice had supported 23 doctors. Regular reviews were undertaken as a way of reinforcing effective performance, identifying areas for improvement and reviewing strengths.	

Staff were provided with protected learning time to support their training and development needs. A team away day had been booked to take place shortly.

One dispenser left the practice in June 2019 to work closer to home, therefore the practice was planning to train up receptionist to fill this post. The practice was currently advertising for a full-time apprentice receptionist and a replacement for the community and care co-ordinator (CCC) vacancy.

### Examples of continuous learning and improvement

Since the last inspection the dispensary had been refurbished which incorporated a modern design layout. This included scanning equipment for checking stock and items in the dispensary. A new pharmacist had joined the team who provided two sessions a month.

The PPG had continued to help with funding equipment for the practice. Including the purchase of 24-hour blood pressure equipment, a Doppler machine (an ultrasound non-invasive test that can be used to estimate the blood flow through blood vessels), two new couches, new drawers in the dispensary and a text messaging service.

In August 2018, the practice obtained a fractional exhaled nitric oxide (FeNo) machine providing a safe and simple method of measuring airway inflammation; a complementary tool to other methods of assessing airways disease in asthma patients.

With the support of the patient participation group (PPG) the practice had set up and continued to manage a Dementia Café held one afternoon a month at the local chapel. The café was attended by around 10-15 members of the practice. Patients were able to enjoy an afternoon of social activities organised by practice and enjoy cakes that were donated.

A new telephone system had been installed in August 2018 with a standardised message from a GP partner. Patients told us they had welcomed the new system. However, they considered the message needed revising as it was too long.

A designated staff car parking area was under development to provide additional car parking at the rear of the practice.

In conjunction with other local practices, the practice was developing a primary care network (PCN) consisting of nice local practices in South East Shropshire to create a fully integrated community-based health service.



## 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.
- 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.

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>

### 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.