

Care Quality Commission

Inspection Evidence Table

Hightown Village Surgery (1-5491662437)

Inspection date: 19 November 2019

Date of data download: 04 November 2019

Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Safe

Rating: Requires improvement

We rated the practice as requires improvement for providing safe services as some aspects of managing risks were not fully effective.

Safety systems and processes

Not all systems, practices and processes were sufficient to keep people safe and safeguarded from abuse.

| Safeguarding | Y/N/Partial |
|--|-------------|
| There was a lead member of staff for safeguarding processes and procedures. | Y |
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Y |
| There were policies covering adult and child safeguarding which were accessible to all staff. | Y |
| Policies took account of patients accessing any online services. | Y |
| Policies and procedures were monitored, reviewed and updated. | Y |
| Partners and staff were trained to appropriate levels for their role. | Partial |
| There was active and appropriate engagement in local safeguarding processes. | Y |
| The Out of Hours service was informed of relevant safeguarding information. | Y |
| There were systems to identify vulnerable patients on record. | Y |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Partial |
| Staff who acted as chaperones were trained for their role. | Y |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm. | Y |
| Explanation of any answers and additional evidence: | |

| Safeguarding | Y/N/Partial |
|--|-------------|
| <p>A register of children at risk was in place and this was reviewed with health visitors to ensure the information held was up to date.</p> <p>Alerts were recorded on the electronic patient records system to identify if a child or adult was at risk.</p> <p>A system was in place to ensure all policies and procedures including safeguarding were regularly reviewed and staff had ready access to all policies and procedures.</p> <p>Disclosure and Barring Service checks were in place for two of the newest members of the staff team whose records we looked at. However, these were not up to date at the time of staff appointments.</p> <p>Not all members of the nursing team had undergone safeguarding training to level 3 in keeping with best practice guidance.</p> | |

| Recruitment systems | Y/N/Partial |
|---|-------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Partial |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>As above DBS checks were in place for the two newest members of staff whose recruitment we looked at but these were not recent checks.</p> <p>The practice was running with a small staff team and there were several vacancies. These were being covered by members of staff from the provider's main practice. This included GP cover, advanced nurse practitioner, practice nurse, health care assistant, practice manager and reception team.</p> <p>The practice offered clinician sessions per week as agreed with NHS England. These were provided by a mix of GP and advanced nurse practitioner sessions. GP cover was provided for full days on Mondays and Fridays and half days for the remainder of the week. A telephone triage was provided at the provider's main site at times when there was no GP located at the practice and patients could be booked into the provider's main practice site for GP appointments.</p> | |

| Safety systems and records | Y/N/Partial |
|---|-------------|
| <p>There was a record of portable appliance testing or visual inspection by a competent person.</p> <p>Date of last inspection/test: 05/07/2019</p> | Y |
| <p>There was a record of equipment calibration.</p> <p>Date of last calibration: 20/06/2019</p> | Y |
| There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. | Y |
| There was a fire procedure. | Y |
| <p>There was a record of fire extinguisher checks.</p> <p>Date of last check: August 2019</p> | Y |
| There was a log of fire drills. | Y |

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|---|---|
| Date of last drill: 18/07/2019 | |
| There was a record of fire alarm checks. Date of last check: 18/11/2019 | Y |
| There was a record of fire training for staff. Date of last training: 03/07/2019 | Y |
| There were fire marshals. | Y |
| A fire risk assessment had been completed. Date of completion: 03/07/2019 | |
| Actions from fire risk assessment were identified and completed. | Y |

| Health and safety | Y/N/Partial |
|---|-------------|
| Premises/security risk assessment had been carried out. Date of last assessment: November 2019 | Y |
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: | N |
| <p>Explanation of any answers and additional evidence:</p> <p>Health and safety related policies and procedures were in place. However, a health and safety risk assessment had not been carried out.</p> <p>Not all areas of the premises were safe. Both stair cases presented a potential risk as one was a spiral metal staircase and the other had uneven stairs and presented a risk. A notice had been put up to alert people to this but there had been no action taken to remedy the cause of the risk. A treatment room was located on the first floor, but this was not in use at the time of the visit. However, staff facilities and other rooms were located on the first floor.</p> <p>The entrance for access for people with mobility aids or requiring wheelchair access was located at the side of the building. The width of an internal doorway and means of opening doors meant areas of the ground floor were not as accessible as could be for people who are disabled.</p> <p>Pest control arrangements were not appropriate and could present a health and safety infection control risk.</p> <p>Areas of the building required maintenance, particularly one of the ceilings on the first floor showed signs of damp and had cracks. An area in the side entrance also showed signs of damp. Flooring needed to be replaced in some areas.</p> | |

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

| | Y/N/Partial |
|--|-------------|
| There was an infection risk assessment and policy. | Y |
| Staff had received effective training on infection prevention and control. | Y |
| Infection prevention and control audits were carried out. | Y |

| | |
|--|---|
| Date of last infection prevention and control audit: 01/11/2019 | |
| The practice had acted on any issues identified in infection prevention and control audits. | Y |
| There was a system to notify Public Health England of suspected notifiable diseases. | Y |
| The arrangements for managing waste and clinical specimens kept people safe. | Y |
| Explanation of any answers and additional evidence: An infection control audit carried out on 01/11/2019 showed some areas that were not fully compliant. Action had been taken to address these. | |

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

| | Y/N/Partial |
|--|-------------|
| There was an effective approach to managing staff absences and busy periods. | Y |
| There was an effective induction system for temporary staff tailored to their role. | Y |
| The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures. | Y |
| Clinicians knew how to identify and manage patients with severe infections including sepsis. | Y |
| Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients. | Y |
| There was a process in the practice for urgent clinical review of such patients. | Y |
| When there were changes to services or staff the practice assessed and monitored the impact on safety. | Y |
| Explanation of any answers and additional evidence: Members of the clinical team had undergone sepsis training. Members of the administrative team were scheduled to receive this training in the near future and had been instructed on sepsis recognition and provided with guidance and protocols. | |

Information to deliver safe care and treatment

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

| | Y/N/Partial |
|---|-------------|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. | Y |
| There was a system for processing information relating to new patients including the summarising of new patient notes. | Y |
| There were systems for sharing information with staff and other agencies to enable them to | Y |

| | |
|---|---|
| deliver safe care and treatment. | |
| Referral letters contained specific information to allow appropriate and timely referrals. | Y |
| Referrals to specialist services were documented and there was a system to monitor delays in referrals. | Y |
| There was a documented approach to the management of test results and this was managed in a timely manner. | Y |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | Y |
| When patients used multiple services, the information needed for their ongoing care was shared appropriately and in line with relevant protocols. | Y |

Appropriate and safe use of medicines

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

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA) | 0.73 | 1.03 | 0.87 | No statistical variation |
| The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2018 to 30/06/2019) (NHSBSA) | 9.4% | 8.4% | 8.6% | 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 (01/01/2019 to 30/06/2019) (NHSBSA) | 6.26 | 5.69 | 5.63 | No statistical variation |
| Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA) | 1.63 | 2.44 | 2.08 | No statistical variation |

| Medicines management | Y/N/Partial |
|--|-------------|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | Y |
| Blank prescriptions were kept securely and their use monitored in line with national guidance. | Y |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Y |
| The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review. | Y |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. | Y |
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services. | Y |
| There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. | Y |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Y |
| There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. | Y |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance. | N/A |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | Y |
| For remote or online prescribing there were effective protocols for verifying patient identity. | Y |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates. | Partial |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Y |
| Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>The practice held a supply of medicines that could be used to treat patients in an emergency. The medicines held were largely in line with guidance but there were two that were not held on the premises. There was no associated risk assessment to support this decision. The provider told us during the inspection that they intended to rectify this and this was confirmed as completed following the inspection visit.</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. | Y |
| Staff knew how to identify and report concerns, safety incidents and near misses. | Y |
| There was a system for recording and acting on significant events. | Y |
| Staff understood how to raise concerns and report incidents both internally and externally. | Y |
| There was evidence of learning and dissemination of information. | Y |
| Number of events recorded in last 12 months: | 2 |
| Number of events that required action: | 2 |

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

| Event | Specific action taken |
|---|---|
| Referral not made appropriately. | Patient referred again under appropriate route and issue raised with clinical team. |
| Incorrect coding for patient condition. | Awareness and re-training provided to staff and audit carried out. |

| Safety alerts | Y/N/Partial |
|---|-------------|
| There was a system for recording and acting on safety alerts. | Partial |
| Staff understood how to deal with alerts. | Y |
| Explanation of any answers and additional evidence: There was a procedure for managing safety alerts that involved forwarding the alerts to designated individuals for action. However, there was no system in place for maintaining oversight of the actions taken or to ensure these had all been fully met. | |

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

| 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) (01/07/2018 to 30/06/2019) <small>(NHSBSA)</small> | 0.81 | 0.93 | 0.75 | No statistical variation |

Older people

Population group rating: Good

| Findings |
|---|
| <ul style="list-style-type: none"> Patients over the age of 65 had a named accountable GP. The practice kept up to date registers of patients with a range of health conditions (including conditions common in older people) and used this information to plan reviews of health care and to offer services such as vaccinations for flu, shingles and pneumonia. Health checks, including frailty assessments, were offered to patients over 75 years of age. The practice carried out structured annual medication reviews for older patients. |

- Nationally reported data showed that outcomes for patients with conditions commonly found in older people at this practice were generally comparable to outcomes for patients locally and nationally.
- On the day appointments allowed for rapid access to meet the needs of older patients with co-morbidities.
- The practice used the 'Gold Standard Framework' (this is a systematic evidence-based approach to improving the support and palliative care of patients nearing the end of their life) to ensure patients received appropriate care.

People with long-term conditions

Population group rating: Good

Findings

- The practice held information about the prevalence of specific long-term conditions within its patient population. This included conditions such as diabetes, chronic obstructive pulmonary disease (COPD), cardio vascular disease and hypertension. The information was used to target service provision, for example to ensure patients who required immunisations received these.
- The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening their clinical record.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. Patients with multiple conditions were reviewed in one visit where possible. 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.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Patients with asthma were offered an asthma management plan.
- Data from 2018 to 2019 showed that the practice was performing comparably to practices locally and nationally for the care and treatment of people with chronic health conditions.
- Patients were provided with advice and guidance about prevention and management of their health conditions and were signposted to support services.

| 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 (01/04/2018 to 31/03/2019) <small>(QOF)</small> | 89.4% | 77.6% | 79.3% | Tending towards variation (positive) |

| | | | | |
|---|------------|-------|-------|--------------------------|
| Exception rate (number of exceptions). | 18.3% (19) | 13.7% | 12.8% | 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 (01/04/2018 to 31/03/2019) <small>(QOF)</small> | 82.2% | 76.0% | 78.1% | No statistical variation |
| Exception rate (number of exceptions). | 2.9% (3) | 10.9% | 9.4% | 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 (01/04/2018 to 31/03/2019) <small>(QOF)</small> | 84.5% | 79.6% | 81.3% | No statistical variation |
| Exception rate (number of exceptions). | 6.7% (7) | 11.4% | 12.7% | 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 (01/04/2018 to 31/03/2019) <small>(QOF)</small> | 76.7% | 72.5% | 75.9% | No statistical variation |
| Exception rate (number of exceptions). | 2.4% (3) | 12.7% | 7.4% | 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 (01/04/2018 to 31/03/2019) <small>(QOF)</small> | 83.9% | 83.8% | 89.6% | No statistical variation |
| Exception rate (number of exceptions). | 18.4% (7) | 13.3% | 11.2% | 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 (01/04/2018 to 31/03/2019) <small>(QOF)</small> | 84.6% | 81.8% | 83.0% | No statistical variation |
| Exception rate (number of exceptions). | 1.4% (5) | 5.7% | 4.0% | 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 | 87.7% | 89.3% | 91.1% | No statistical variation |

| | | | | |
|---|----------|------|------|-----|
| currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) (QOF) | | | | |
| Exception rate (number of exceptions). | 1.7% (1) | 5.8% | 5.9% | N/A |

Families, children and young people

Population group rating: Good

Findings

- Childhood immunisation uptake rates had met 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.
- Young people could access services for sexual health and contraception.
- There were systems in place to identify and follow up children who were at risk.
- A designated lead was in place for safeguarding.
- Staff had undergone regular safeguarding training and those we spoke with had appropriate knowledge about child protection and had ready access to safeguarding policies and procedures
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- The practice's encouraged cancer screening uptake for patients in this age group. Uptake rates were comparable to local and national averages and the provider was trying to increase this to meet the national target.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- Patients were able to use request a telephone consultation and therefore did not always have to attend the practice in person to seek advice, and care and treatment.

| 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) (01/04/2018 to 31/03/2019) (NHS England) | 11 | 12 | 91.7% | Met 90% minimum |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received | 15 | 15 | 100.0% | Met 95% WHO based target |

| | | | | |
|---|----|----|--------|--------------------------|
| Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England) | | | | |
| 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) (01/04/2018 to 31/03/2019) (NHS England) | 15 | 15 | 100.0% | Met 95% WHO based target |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England) | 15 | 15 | 100.0% | 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

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- The practice's encouraged cancer screening uptake for patients in this age group. Uptake rates were comparable to local and national averages.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- Patients were able to use request a telephone consultation and therefore did not always have to attend the practice in person to seek advice, and care and treatment.

| 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) | 75.3% | N/A | 80% Target | Below 80% target |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE) | 78.4% | 63.0% | 72.1% | N/A |

| | | | | |
|---|-------|-------|-------|--------------------------|
| Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) <small>(PHE)</small> | 59.0% | 51.6% | 57.3% | 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) <small>(PHE)</small> | 30.8% | 73.0% | 69.3% | 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) <small>(PHE)</small> | 46.2% | 43.1% | 51.9% | No statistical variation |

Any additional evidence or comments

Patients were encouraged to attend for cervical screening and were offered appointments with the local extended access service to encourage greater uptake.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances in order to provide the services patients required.
- Same day appointments and longer appointments were offered when required.
- Patients who have 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.
- Staff had been provided with training in the forms of abuse and how to recognise it in vulnerable adults.
- Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- Information and advice were available about how patients could access a range of support groups and voluntary organisations.

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

Population group rating: Good

Findings

- The practice held a register of patients experiencing poor mental health and these patients were offered an annual review of their physical and mental health.
- Patients with a mental health condition had a named GP for contact.
- 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.
- Same day and longer appointments were offered when required.
- The practice received higher than average scores for data about how people with mental health needs were supported.

| 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 (01/04/2018 to 31/03/2019) <small>(QOF)</small> | 100.0% | 84.9% | 89.4% | No statistical variation |
| Exception rate (number of exceptions). | 16.7% (1) | 8.1% | 12.3% | 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 (01/04/2018 to 31/03/2019) <small>(QOF)</small> | 100.0% | 86.0% | 90.2% | No statistical variation |
| Exception rate (number of exceptions). | 0.0% (0) | 7.4% | 10.1% | 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 (01/04/2018 to 31/03/2019) <small>(QOF)</small> | 93.8% | 82.4% | 83.6% | No statistical variation |
| Exception rate (number of exceptions). | 0.0% (0) | 6.1% | 6.7% | N/A |

Monitoring care and treatment

The practice had a 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) | 543.5 | No Data | 539.2 |
| Overall QOF score (as a percentage of maximum) | 97.2% | No Data | 96.4% |
| Overall QOF exception reporting (all domains) | 6% | No Data | No Data |

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

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

- An audit into the prescribing of aspirin for patients over 75 years of age had led to these patients being offered proton pump inhibitor medicines.
- An audit into the prescribing of Levothyroxine for patients with subclinical hyperthyroidism lead to review and reassessment of these patients.

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. | Y |
| The learning and development needs of staff were assessed. | Y |
| The practice had a programme of learning and development. | Y |
| Staff had protected time for learning and development. | Y |
| There was an induction programme for new staff. | Y |
| Induction included completion of the Care Certificate for Health Care Assistants 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. | Y |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | Y |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Y |

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 (01/04/2018 to 31/03/2019) (QOF) | Y |
| Staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment. | Y |
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | Y |
| Patients received coordinated care when they moved between services. | Y |

Helping patients to live healthier lives

Staff were proactive in helping patients to live healthier lives.

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

| 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, | 97.6% | 95.1% | 95.0% | No statistical variation |

| | | | | |
|--|----------|------|------|-----|
| diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small> | | | | |
| Exception rate (number of exceptions). | 0.0% (0) | 1.0% | 0.8% | N/A |

Consent to care and treatment

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

| | Y/N/Partial |
|--|-------------|
| Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented. | Y |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. | Y |
| Policies for any online services offered were in line with national guidance. | Y |

Caring

Rating: Good

Kindness, respect and compassion

Feedback from patients was positive about the way staff treated them.

| | Y/N/Partial |
|---|-------------|
| Staff displayed understanding and a non-judgemental attitude towards patients. | Y |
| Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition. | Y |
| Explanation of any answers and additional evidence: Patient feedback in CQC patient comment cards was very positive about how staff treated them. Terms such as 'dignity', 'friendly' and 'respectful' were just some of the terms used. | |

| CQC comments cards | |
|--|----|
| Total comments cards received. | 16 |
| Number of CQC comments received which were positive about the service. | 13 |
| Number of comments cards received which were mixed about the service. | 2 |
| Number of CQC comments received which were negative about the service. | 1 |

| Source | Feedback |
|---------------------------|---|
| Discussions with patients | We spoke with three patients who were attending the practice at the time of our visit. They gave us positive feedback about their experiences of the practice and treatment by members of the clinical and reception team. |
| CQC comment cards | The majority of the 16 patient comment cards we received were positive about the care and treatment provided and in getting an appointment. Patients told us they felt listened to, respected and that they received good clinical care and treatment. A small number of negative comments related to getting an appointment, getting through to the practice at 8am and continuity of the clinical team. |

National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 1982.0 | 278.0 | 117.0 | 42.1% | 5.90% |

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| The percentage of respondents to the GP patient survey who stated that the last time | 82.9% | 88.7% | 88.9% | No statistical variation |

| Indicator | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------------|
| they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2019 to 31/03/2019) | | | | |
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019) | 88.2% | 88.4% | 87.4% | No statistical variation |
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019) | 96.3% | 95.1% | 95.5% | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019) | 75.2% | 84.2% | 82.9% | No statistical variation |

| Question | Y/N |
|---|-----|
| The practice carries out its own patient survey/patient feedback exercises. | N |

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

| | Y/N/Partial |
|---|-------------|
| Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given. | Y |
| Staff helped patients and their carers find further information and access community and advocacy services. | Y |

National GP Survey results

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019) | 96.3% | 93.0% | 93.4% | No statistical variation |

| | Y/N/Partial |
|---|-------------|
| Interpretation services were available for patients who did not have English as a first language. | Y |
| Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations. | Y |
| Information about support groups was available on the practice website. | Y |

| Carers | Narrative |
|---|--|
| Percentage and number of carers identified. | 42 carers had been identified. This equates to 2% of the patient population. |
| How the practice supported carers (including young carers). | Information on carers support was displayed in the reception area and waiting room. Carers were signposted to local support services and could be given priority for appointment requests. |
| How the practice supported recently bereaved patients. | Condolence cards were sent to recently bereaved patients and staff signposted patients to support services. |

Privacy and dignity

The practice respected patients' privacy and dignity.

| | Y/N/Partial |
|--|-------------|
| Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. | Y |
| Consultation and treatment room doors were closed during consultations. | Y |
| A private room was available if patients were distressed or wanted to discuss sensitive issues. | Y |
| There were arrangements to ensure confidentiality at the reception desk. | Y |

Responsive

Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

| | Y/N/Partial |
|--|-------------|
| The practice understood the needs of its local population and had developed services in response to those needs. | Y |
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided. | Y |
| The facilities and premises were appropriate for the services being delivered. | Partial |
| The practice made reasonable adjustments when patients found it hard to access services. | Partial |
| There were arrangements in place for people who need translation services. | Y |
| Explanation of any answers and additional evidence: The practice did not provide appropriate access for people who use mobility aids or a wheelchair. | |

| Practice Opening Times | |
|--|--|
| Day | Time |
| Opening times: | |
| Monday | 8am - 6.30pm |
| Tuesday | 8am - 6.30pm |
| Wednesday | 8am - 6.30pm |
| Thursday | 8am - 6.30pm |
| Friday | 8am - 6.30pm |
| Appointments available: | |
| Monday | 8am - 5.30pm |
| Tuesday | 8am - 5.30pm |
| Wednesday | 8am - 5.30pm |
| Thursday | 8am - 5.30pm 6.30pm – 7.30pm E consult and telephone consultations. |
| Friday | 8am - 5.30pm |
| Patients could access GPs seven days per week as part of the local Clinical Commissioning Group wide extended hours service. This was available from 5pm to 8pm Monday to Friday and 9am to 1pm Saturdays and Sundays. | |

National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 1982.0 | 278.0 | 117.0 | 42.1% | 5.90% |

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019) | 93.8% | 94.9% | 94.5% | No statistical variation |

Older people

Population group rating: Good

Findings

- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Good

Findings

- There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Population group rating: Good

Working age people (including those recently retired and students)

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Patients were encouraged to utilise the CCG wide extended hours provision.
- The practice was proactive in offering online services including the booking of appointments and requests for repeat prescriptions.
- Electronic prescribing was provided.
- The practice provided telephone consultations.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- Same day appointments could be provided for patients whose circumstances made them vulnerable and longer appointments were available for patients with enhanced needs.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to patients experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted patients to these accordingly.

Timely access to the service

People were able to access care and treatment in a timely way.

National GP Survey results

| | Y/N/Partial |
|--|-------------|
| Patients with urgent needs had their care prioritised. | Y |
| The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. | Y |
| Appointments, care and treatment were only cancelled or delayed when absolutely necessary. | Y |

| Indicator | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------------|
| 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 (01/01/2019 to 31/03/2019) | 66.2% | N/A | 68.3% | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019) | 61.7% | 67.1% | 67.4% | No statistical variation |
| The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019) | 56.2% | 64.3% | 64.7% | No statistical variation |
| The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019) | 67.9% | 74.4% | 73.6% | No statistical variation |

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

| Complaints | |
|--|---|
| Number of complaints received in the last year. | 4 |
| Number of complaints we examined. | 2 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 2 |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman. | 0 |

| | Y/N/Partial |
|---|-------------|
| Information about how to complain was readily available. | Y |
| There was evidence that complaints were used to drive continuous improvement. | Y |

Example(s) of learning from complaints.

| Complaint | Specific action taken |
|--|---|
| Patient given incorrect advice by a member of staff regarding a prescription. | An apology was made to the patient and the mistake was rectified. |
| Patient not happy with how they were dealt with by a member of the staff team. | An apology was made to the patient and the matter was discussed with staff member and additional training was provided. |

Well-led

Rating: Good

Leadership capacity and capability

Leaders demonstrated that they had the capacity and skills to deliver high quality sustainable care.

| | Y/N/Partial |
|--|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | Y |
| They had identified the actions necessary to address these challenges. | Y |
| Staff reported that leaders were visible and approachable. | Y |
| There was a leadership development programme, including a succession plan. | Y |
| Explanation of any answers and additional evidence: The provider clearly understood the challenges to the service and was working to address these. A major challenge was staffing at all levels. In recent months the practice had lost a salaried GP, practice nurse and more recently a practice manager. There were also staff absences in the administrative/reception team. Staff from the provider's main practice were filling these roles and recruitment was underway. Patients were also asked to attend appointments at the provider's main location. This was mainly for appointments with members of the nursing team for people who required monitoring for a long term condition. Staffing at a clinical level had been agreed with NHS England as part of the contractual arrangements. | |

Vision and strategy

The practice had a vision and strategy to provide good quality sustainable care.

| | Y/N/Partial |
|---|-------------|
| The practice had a clear vision and set of values that prioritised quality and sustainability. | Y |
| There was a realistic strategy to achieve their priorities. | Y |
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | Y |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Y |
| Progress against delivery of the strategy was monitored. | Y |

Culture

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

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

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

| Source | Feedback |
|--|--|
| Discussions with members of the staff team | Staff we spoke with told us they had been through a lot of changes over recent years with different providers running the practice. They told us they felt supported in their role currently and were confident to raise issues. |

Governance arrangements

The overall governance arrangements were effective.

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

Managing risks, issues and performance

Processes for managing risks, issues and performance were in place. However, some of the processes for managing risks were not fully effective.

| | Y/N/Partial |
|--|-------------|
| There were assurance systems which were regularly reviewed and improved. | Y |

| | |
|---|---------|
| There were processes to manage performance. | Y |
| There was a systematic programme of clinical and internal audit. | Y |
| There were effective arrangements for identifying, managing and mitigating risks. | Partial |
| A major incident plan was in place. | Y |
| Staff were trained in preparation for major incidents. | Y |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Y |
| Explanation of any answers and additional evidence: | |
| Overall we found that the provider had good governance systems in place particularly for the clinical care provided. However, we found a number of areas of practice within the safe key question that would indicate a shortfall in some of the processes for managing risks. For example, there was no health and safety risk assessment, not all areas of the building were safe or appropriate to meet patients' needs, the management of patient safety alerts was not robust and staff recruitment checks for Disclosure and Barring Service checks were not in line with requirements. | |

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. | Y |
| Performance information was used to hold staff and management to account. | Y |
| Our inspection indicated that information was accurate, valid, reliable and timely. | Y |
| Staff whose responsibilities included making statutory notifications understood what this entails. | Y |

If the practice offered online services:

| | Y/N/Partial |
|--|-------------|
| The provider was registered as a data controller with the Information Commissioner's Office. | Y |
| Patient records were held in line with guidance and requirements. | Y |

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

| | Y/N/Partial |
|--|-------------|
| Patient views were acted on to improve services and culture. | Y |
| The practice had an active Patient Participation Group. | Y |
| Staff views were reflected in the planning and delivery of services. | Y |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Y |

Feedback from Patient Participation Group.

| Feedback |
|---|
| We met with a member of the Patient Participation Group (PPG). They told us the provider met with the PPG on a quarterly basis and that they were receptive in dealing with issues raised in a timely manner. |

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

| | Y/N/Partial |
|--|-------------|
| There was a strong focus on continuous learning and improvement. | Y |
| Learning was shared effectively and used to make improvements. | Y |

Examples of continuous learning and improvement

| |
|--|
| <p>The practice was involved in locality working to improve outcomes for patients. For example, the practice was involved in the Primary Care Network.</p> <p>The provider told us they had plans for developing the services they provided. Examples of this included; improving their system for call and recall of patients who have long term conditions to promote better outcomes for these patients, improvement to the phone system to include a web-based system and the introduction of an on-line patient consultation service.</p> |
|--|

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.