

Care Quality Commission

Inspection Evidence Table

The Colne Practice (1-543856754)

Inspection date: 29 January 2020

Date of data download: 06 February 2020

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 because:

- The practice's systems for the appropriate and safe use of medicines, including medicines optimisation were not always comprehensive.
- Although not part of the requirement notice due to the practice's immediate actions, or the level of concern, there were some issues that contributed to the requires improvement rating for the safe key question. They included those relating to: non-clinical staff DBS checks, staff vaccinations, and health and safety and premises risk related processes and documentation.

Safety systems and processes

In most cases, the practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies 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

Safeguarding	Y/N/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
<p>Explanation of any answers and additional evidence:</p> <p>All the staff we spoke with demonstrated they understood the relevant safeguarding processes and their responsibilities. Most staff had completed adult and child safeguarding training to the appropriate level for their roles. Some recently employed non-clinical staff were yet to complete the training.</p> <p>All clinical staff and the practice manager had received a DBS check in accordance with the practice's policy. All other non-clinical staff had not received a DBS check and were not risk assessed as to why they didn't require a DBS check. Most of the non-clinical staff had not completed chaperone training. Senior staff we spoke with said the practice policy was to use nurses as chaperones and that non-clinical staff did not chaperone. We looked at the practice's chaperone policy which confirmed this approach. All the non-clinical staff we spoke with during our inspection told us that at some point, even if occasionally, they had been asked to chaperone. This was not in accordance with the practice's chaperone policy. These staff had all completed chaperone training. As with all other non-clinical staff (except the practice manager), they had not received a DBS check and were not risk assessed as to why they didn't require one.</p> <p>The practice took immediate action and following our inspection, they provided us with evidence that demonstrated 16 non-clinical staff had received or were in the process of receiving a DBS check. Two absent non-clinical staff were not included in this process and the checks would be completed on their return to work.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	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>During our inspection, the practice couldn't demonstrate that all staff had received the required vaccinations for their roles. We saw that for six GPs and all the nurses, there were no records of BCG vaccination. No complete records of tetanus/polio/diphtheria vaccination were available for the 12 patient-facing (direct patient contact) non-clinical staff. There were no risk assessments in place for these staff. We looked at minutes of meetings and documented communications which demonstrated that in 2019 the practice had explained the vaccination requirement to all staff who were requested to provide evidence of all their vaccinations and obtain the relevant blood tests if necessary. This had resulted in some action, including but not limited to ensuring that all nurses and the relevant non-clinical staff were recorded as having received the vaccination, or provided a positive antibody test for measles, mumps and rubella (MMR). It had not resolved all the gaps in staff vaccinations.</p> <p>The practice took immediate action and following our inspection, they provided us with evidence that demonstrated that 10 patient-facing non-clinical staff previously without evidence of their tetanus/polio/diphtheria had received the vaccination. The two absent non-clinical staff would be</p>	

reviewed on their return to work. Five GPs and two nurses had provided evidence of previously receiving their BCG vaccination. The practice had contacted the local TB (tuberculosis) nurse seeking advice on how to arrange an immunity test for the remaining GP.

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: May 2019.	Y
There was a record of equipment calibration. Date of last calibration: July 2019 and December 2019 (for some specialist equipment).	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
There was a record of fire extinguisher checks. Date of last check: March 2019.	Y
There was a log of fire drills. Date of last drill: November 2019.	Y
There was a record of fire alarm checks. Date of last check: Weekly test records were completed throughout 2019 and there was an alarm service and inspection in October 2019.	Y
There was a record of fire training for staff. Date of last training: Between November 2018 and January 2020.	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: January 2020.	Y
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: September 2019.	Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: September 2019.	Partial
Explanation of any answers and additional evidence: We saw that a premises and health and safety risk assessment document was completed in September 2019. This detailed areas of risk and the mitigating actions in place to reduce or resolve the risks. Other health and safety related documented processes available lacked some detail and structure. A premises audit completed in January 2019 did not clearly identify risks or actions to reduce those risks. Health and safety checklists done in April and November 2019 were not fully completed and had no structured action plans. A list of completed actions was available. A Legionella risk assessment was completed in July 2016. (Legionella is a term for a particular bacterium	

which can contaminate water systems in buildings). The accompanying action plan was not completed. Despite the absence of an action plan, we saw evidence of actions taken to maintain water safety standards. Contracted service visit logs and certificates were available which showed water testing, and cleaning and disinfecting of the water tanks and supply were completed throughout 2018 and 2019. The practice completed water temperature checks, although there were gaps in the records we looked at. These showed hot water temperatures at the practice were sometimes below the required levels, including as recently as November 2019.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: April 2019.	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: We saw the practice was visibly clean and tidy. There were appropriate processes in place for the management of sharps (needles) and clinical waste. Hand wash facilities, including hand sanitiser were available throughout the practice. Infection control audits were completed. Staff had completed infection control training and the staff we spoke with were knowledgeable about infection control processes relevant to their roles. Most of the GP consultation rooms contained carpet flooring which was not wipe clean. All the staff we spoke with were clear that the practice reduced the risk of contamination to the floors in those rooms by completing any procedures where there was an identified risk in the nurse treatment rooms, which contained wipe clean flooring. This approach was not formally documented.	

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
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	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	Y

sepsis.	
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
<p>Explanation of any answers and additional evidence:</p> <p>During our inspection, we saw that built-in emergency buttons were available on the computers throughout the practice.</p> <p>The staff we spoke with said temporary staff, including agency nurses and temporary locum GPs were rarely, if ever used at the practice. We saw a suitable induction process was in place for these staff if required.</p> <p>We saw that all staff had access to a level of sepsis training appropriate to their roles, either through an online facility or attendance at externally provided training. The staff we spoke with demonstrated a good understanding of the condition and their role in identifying patients with presumed sepsis and ensuring their urgent clinical review. Appropriate guidelines were available for staff to follow.</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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
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
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.	Y

Appropriate and safe use of medicines

The practice's systems for the appropriate and safe use of medicines, including medicines optimisation were not always comprehensive.

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) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.97	0.84	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). (01/10/2018 to 30/09/2019) (NHSBSA)	11.1%	9.5%	8.5%	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 (01/04/2019 to 30/09/2019) (NHSBSA)	6.24	5.87	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	1.83	1.60	2.08	No statistical variation
<p>Explanation of any answers and additional evidence:</p> <p>As part of the practice's efforts to adhere to appropriate antibacterial prescribing, C-reactive protein (CRP) tests were used. (A CRP test is a simple point-of-care blood test that can provide an assessment of inflammation in the body. High CRP levels suggest an infection is bacterial and may require antibiotic treatment in adherence with national guidelines). The practice had completed 90 such tests on patients presenting with symptoms of a chest infection in the past two months to ensure antibiotics were only prescribed when necessary.</p>				

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).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision	N/A

Medicines management	Y/N/Partial
or peer review.	
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.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	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>Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. At the time of our inspection, these were not always appropriately managed. We looked at 23 PGDs and found that in 13 cases these were appropriately completed. We saw seven where at least one nurse had signed their review and understanding of the PGD after a GP had signed their authorisation on behalf of the practice. We saw three PGDs which were not signed by a GP and the nurses were working within the PGD without the appropriate authorisation. The practice took immediate action and following our inspection, they provided us with evidence that demonstrated nine PGDs, including current versions and new versions with imminent validity had been appropriately signed by the nurses and countersigned by a GP on or before 4 February 2020.</p> <p>We looked at the practice's emergency medicines and saw that one EpiPen (an adrenaline auto-injector) had expired in November 2019. We spoke with practice staff about this. They told us this was not an oversight and was in adherence with a Medicines and Healthcare products Regulatory Agency (MHRA) alert in 2019 which advised the shelf-life of these devices could be extended as a period of supply difficulties was being experienced. The practice had assessed it was safer to keep the EpiPen beyond its expiry date than to dispose of it and not be able to obtain a replacement. We saw that all other emergency medicines were within their expiry dates and a comprehensive monitoring system was in place and adhered to. The practice took immediate action and following our inspection, they provided us with evidence that a different brand of adrenaline auto-injector with an expiry date of</p>	

Medicines management	Y/N/Partial
<p>October 2020 had been obtained.</p> <p>We reviewed a sample of patients on any one of three different types of high-risk medicines. For all the patients prescribed two of these medicines, we found their care, treatment and review was well managed. For three patients on one of the medicines, we found they were overdue the relevant blood tests but had been prescribed the medicine at some point between October 2019 and January 2020. In one of these cases, the blood test had subsequently been completed 12 days after the medicine was prescribed to the patient. The practice attempted to contact the remaining two patients during our inspection requesting they attend the practice for the appropriate blood tests. The practice took further immediate action and following our inspection, they provided us with evidence that demonstrated one of the patients had received the appropriate blood test at the practice in the first week of February 2020. After unsuccessful attempts to phone and email the other patient, they had been written to along with another care provider to ensure their future care was appropriately managed. Both patients were removed from repeat prescribing of the relevant medicine.</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:	Nine
Number of events that required action:	Nine
<p>Explanation of any answers and additional evidence:</p> <p>There was an effective system in place for reporting and recording incidents and significant events. The staff we spoke with were clear on the reporting process used at the practice and we found that lessons learnt were shared to make sure action was taken to improve safety in the practice.</p>	

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

Event	Specific action taken
Blood samples for testing were not collected and not all staff knew how to respond.	One of the GPs took the blood samples to the local lab for testing. A new pathology collection policy was developed, disseminated and discussed that detailed the roles and responsibilities of staff in relation to blood sample management.
The practice lost its network and phone connections due to an external incident and phones were not restored until the following day.	The practice upgraded its service agreement with the telephone provider for a higher level of cover to ensure phone reconnection within six hours of any incident.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw a process was in place and adhered to for the receipt, review and monitoring of action taken in response to safety alerts including Medicines and Healthcare products Regulatory Agency (MHRA) alerts. We saw examples of actions taken in response to recent alerts, including one regarding sodium valproate (a medicine primarily used in the treatment of epilepsy).</p>	

Effective

Rating: Good

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	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
<p>Explanation of any answers and additional evidence:</p> <p>The practice assessed needs and delivered care in line with relevant and current evidence-based guidance and standards. The practice had systems in place to keep all clinical staff up-to-date. Staff had access to National Institute for Health and Care Excellence (NICE) best practice guidelines and templates based on best practice guidelines. They used this information to deliver care and treatment that met patients' needs.</p>	

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) (01/10/2018 to 30/09/2019) (NHSBSA)	0.89	0.58	0.74	No statistical variation

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. Health checks were offered to patients over 75 years of age and 68 of these checks were completed in 2018/2019.

- 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.
- As part of a local initiative, the practice was aligned to one main care home. Using a system of rotation, a GP from the practice visited the home on a structured weekly basis to provide continuity of care and ensure residents' health needs were met.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Older people had access to targeted immunisations such as the flu vaccination. The practice had 2,030 patients aged over 65 years. Of those, 1,425 (70%) had received the flu vaccination in the 2018/2019 year.
- Staff could recognise the signs of abuse in older patients and knew how to escalate any concerns.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the clinicians 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 could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- GPs followed up patients who had received treatment in hospital or through out-of-hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardio-vascular disease and prescribed statins had their care appropriately managed at the practice.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- All newly diagnosed patients with diabetes were managed in line with an agreed pathway.
- The practice followed up on patients with long-term conditions discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice provided its own anticoagulation clinic to monitor the treatment of patients taking oral anticoagulant medicines (medicines that help prevent blood clots). This included the provision of the appropriate blood tests. This service was led by one of the GPs and the nurses.

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>	75.1%	79.6%	79.3%	No statistical variation
Exception rate (number of exceptions).	9.6% (54)	13.0%	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>	73.0%	75.9%	78.1%	No statistical variation
Exception rate (number of exceptions).	10.1% (57)	10.3%	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>	83.8%	81.7%	81.3%	No statistical variation
Exception rate (number of exceptions).	13.3% (75)	11.8%	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>	76.1%	75.9%	75.9%	No statistical variation
Exception rate (number of exceptions).	4.3% (25)	5.9%	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>	94.5%	91.3%	89.6%	No statistical variation
Exception rate (number of exceptions).	6.3% (11)	10.1%	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>	85.0%	82.6%	83.0%	No statistical variation
Exception rate (number of exceptions).	3.2% (49)	3.7%	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 currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) <small>(QOF)</small>	93.3%	91.0%	91.1%	No statistical variation
Exception rate (number of exceptions).	3.9% (8)	4.9%	5.9%	N/A

Any additional evidence or comments

During our inspection, we reviewed the care provided to patients with long-term conditions and found these patients had received appropriate reviews or had been invited for a review. We found the practice had an organised approach towards appropriately managing the care of these patients.

We discussed any areas of above averages exception reporting with senior clinical staff during our inspection. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This related to the individual clinical and public health domains for cancer (31.8% exception reporting), depression (27.9% exception reporting), mental health (24.4% exception reporting) and cardiovascular disease (50% exception reporting). The practice's current unverified data showed exception reporting was much lower in all these areas at the time of our inspection. In all the cases we looked at exception reporting was clinically appropriate.

Families, children and young people

Population group rating: Good

Findings

- The practice met the World Health Organisation (WHO) based target of 95% (the recommended standard for achieving herd immunity) for all four childhood immunisation uptake indicators.
- 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.
- A range of contraceptive and family planning services were available.
- There were six-week post-natal and child health checks.
- 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.

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)	76	79	96.2%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	113	118	95.8%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	115	118	97.5%	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)	113	118	95.8%	Met 95% WHO based target

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information:
<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings
<ul style="list-style-type: none"> 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. The practice had 4,598 patients eligible to receive an NHS health check. Of those, 293 had been invited for and 195 had received a health check in the past 12 months. Patients could book or cancel appointments online, access test results, and order repeat medicines without the need to attend the surgery. Public Health England data for the quarter 1 July to 30 September 2019 showed the practice was below the national 80% target for the percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period. The practice's own unverified data showed there had been some improvement by the time of our inspection, although the practice was yet to achieve the 80% target.

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). (01/07/2019 to 30/09/2019) (Public Health England)	72.0%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	76.0%	69.3%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	56.8%	55.8%	58.0%	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. (01/04/2018 to 31/03/2019) (PHE)	61.4%	73.5%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	37.5%	51.4%	53.8%	No statistical variation

Any additional evidence or comments
<p>There was evidence to suggest the practice encouraged its relevant patients to engage with nationally run and managed screening programmes.</p> <p>Public Health England data for the quarter July to September 2019 showed the practice was below the national 80% target for the percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period. We looked at the practice's own unverified data. This showed that at the time of our inspection, 72% of eligible patients aged under 50 years and 77% of eligible patients aged over 50 years were screened adequately within a specified period.</p> <p>We spoke with practice staff about their efforts to achieve 80% attainment (the threshold set for the National Health Service Cervical Screening Programme to be effective). We found the practice had introduced a comprehensive follow up and reminder system for patients who did not attend for their cervical screening test. They demonstrated how they encouraged uptake of the screening programme, for example, by ensuring a female sample taker was available. All the practice nurses completed cervical screening tests, and these could be accessed at any time the nurses were working and not just in specified clinics.</p> <p>The practice took immediate action and following our inspection, they provided us with evidence that demonstrated they had amended their cervical screening protocol. This included that the practice would now contact eligible women by block text or letter in their birth month inviting them to make a cervical screening appointment at the practice. Any non-responders would be followed up in the same month. One of the practice nurses would now provide a clinic from 7.30am one morning each week to provide increased flexibility for working women to attend for their cervical screening. Since our inspection, and as</p>

part of this new approach, 30 women had been telephoned or opportunistically spoken with and had appointments booked to receive their cervical screening test.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held registers of patients living in vulnerable circumstances including those with a learning disability, homeless people, and those with cognitive impairments, literacy or language difficulties.
- 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 regularly worked with multi-disciplinary teams in the case management of vulnerable people.
- The practice reviewed young patients at local residential homes when necessary.

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.
- There was a system for following up patients who failed to attend for administration of long-term medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. We saw the practice had recently developed its own clinical template to assess an individual's risk of suicide or self-harm and found this was comprehensive. Although not yet in use, it was due to be implemented imminently.
- 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.
- All staff had access to an online training module on dementia.

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) ^(QOF)	93.8%	93.0%	89.4%	No statistical variation
Exception rate (number of exceptions).	27.3% (12)	7.5%	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) ^(QOF)	97.4%	92.3%	90.2%	No statistical variation
Exception rate (number of exceptions).	11.4% (5)	6.6%	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) ^(QOF)	98.6%	88.7%	83.6%	Variation (positive)
Exception rate (number of exceptions).	5.3% (4)	5.2%	6.7%	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)	550.0	543.4	539.2
Overall QOF score (as a percentage of maximum)	98.4%	97.3%	96.7%
Overall QOF exception reporting (all domains)	4.7%	5.2%	5.9%

	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

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

We looked at the details of five clinical audits. These were full cycle (repeated) audits or part of a full cycle programme (scheduled to be repeated) where the data was analysed and clinically discussed, and the practice approach was reviewed and modified as a result when necessary. Findings were used by the practice to improve services.

The practice completed an audit to check their prescribing of a medicine used to treat asthma adhered to relevant safety alerts and national guidelines. The practice identified 13 patients who were prescribed the medicine as monotherapy (without an additional medicine that reduces the risk of serious complications). Eleven of these patients were changed to a combination medicine and the remaining two patients continued with the medicine but were also prescribed the additional risk reducing medicine. The results were clinically discussed, and the new process reinforced. On repeating the audit, no patients were prescribed the medicine as monotherapy.

An audit was completed to ensure patients with type-two diabetes and prescribed a medicine to help manage the condition had the optimum blood glucose levels as recommended by national guidelines. The practice identified four patients whose blood glucose levels did not meet the requirements and took appropriate clinical action to manage these patients. On repeating the audit, all patients on the medicine had optimum blood glucose levels.

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.	Partial
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:	

Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included role-specific training and updating for relevant staff, the use of an e-learning facility and protected learning sessions as part of Clinical Commissioning Group target days and twice-yearly half-day all staff sessions when the practice was closed.

At the time of our inspection, all applicable staff members had received an appraisal in the last 12 months.

There were two healthcare assistants (HCAs) at the practice. One was employed before April 2015 and as such their induction didn't include completion of the Care Certificate. The one employed since 2015 told us they had started the Care Certificate upon starting employment in 2017, but this was not yet completed. We found that at the time of our inspection, both the HCAs were completing the General Practice Foundation HCA competency framework. Modules on such things as health and safety and personal development included competency sessions observed by one of the practice nurses who then signed the modules as completed.

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 three-monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Y
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.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. We saw evidence that multi-disciplinary team meetings to discuss the needs of complex patients, including those with end of life care needs, took place monthly. These patients' care plans were routinely reviewed and updated.</p>	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
Explanation of any answers and additional evidence: We saw the practice maintained a high level of achievement for providing annual reviews for patients with a learning disability and those experiencing dementia. There were 54 patients on the practice's learning disability register at the time of our inspection. Of the 39 eligible patients aged 14 years and over, 37 (95% of the eligible total) had received a health review in the past 12 months. For patients experiencing dementia, 71 of the 76 (93%) eligible patients had received a review.	

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	97.6%	94.7%	95.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	0.6% (14)	0.8%	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.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y

Policies for any online services offered were in line with national guidance.	Y
Explanation of any answers and additional evidence: We saw the process for seeking consent was well adhered to and examples of documented informed patient consent for recent procedures completed at the practice were available.	

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.	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: At the time of our inspection, the provider partnership was mostly stable and staff turnaround was minimal. The practice maintained an ongoing readiness for succession planning should this be necessary. A considerable recent challenge for the practice had been the migration to a different clinical IT system. Some technical difficulties had left the practice without a fully functioning system. During our inspection, we found they were pursuing resolution of any issues and were managing the situation well. In response to increased demands on primary care, the practice had joined a recently created Primary Care Network (PCN) and was embracing new ways of working as part of this wider network. A clinical pharmacist was employed by the PCN and worked from the practice for 12 hours each week. This was in addition to the practice's own directly employed clinical pharmacist. A social prescriber was also due to be employed by the PCN.	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: The practice had a written business development plan which detailed the challenges faced by the practice, areas of sustainability, and the aims and objectives of the service. A monthly partners meeting was used to monitor the strategic direction of the practice throughout the year, including any evolving needs or areas of focus. Some of the main areas of strategic focus for the practice throughout 2019 were managing the increasing demands on the practice and the significance of Primary Care Networks (PCNs) in how GP practices operate moving forwards. This would continue to be a focus for the practice	

in 2020, along with such things as staff training and increased patient engagement.

Culture

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

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

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

Source	Feedback
Staff interviews.	The staff we spoke with said there was an open culture within the practice and they had the opportunity to raise and discuss any issues directly with other staff or at meetings and felt confident in doing so and well supported if they did. They told us they felt respected, valued and well supported and knew who to go to in the practice with any concerns. They said they felt their wellbeing was a priority for the practice. Staff were involved in discussions about how to run and develop the practice and were encouraged to identify opportunities to improve the service delivered by 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.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<p>The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This was demonstrated by such things as the availability of and adherence to most practice specific policies. There was a clear protocol in place for how decisions were agreed and a regular schedule of meetings at the practice for individual staff groups, multi-disciplinary teams and all staff to attend supported this.</p> <p>There were named members of staff in lead roles. There were nominated GP leads for safeguarding, prescribing and patients with dementia, diabetes and end of life care needs among others. There were also nominated nurse leads for patients with diabetes and respiratory conditions. We saw there was a clear staffing structure and found that staff understood their roles and responsibilities and those of others.</p>	

Managing risks, issues and performance

There were some clear and effective processes for managing risks, issues and performance. Where processes were not effective and when practicable, the practice responded immediately to rectify this.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a 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:	
<p>Where we identified any concerns during our inspection and when practicable, the practice took action to respond or plans of action were developed to ensure any issues were resolved. For example, those in relation to the appropriate authorisation of Patient Group Directions (PGDs), staff vaccination, staff Disclosure and Barring Service (DBS) checks, the emergency medicines supply, the appropriate management of patients prescribed high-risk medicines, and improving the uptake of cervical screening tests.</p>	

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
Explanation of any answers and additional evidence:	
We found the practice used accurate and reliable data and indicators to understand and monitor the performance of the practice. There was a programme of clinical and internal audit which was used to monitor quality and to make improvements.	

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
Any unusual access was identified and followed up.	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, although there was no active Patient Participation Group.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	N
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
The staff we spoke with said they were encouraged to actively participate in practice life and share their views. An open culture among staff and management supported this.	
The relevant staff we spoke with told us there was no active Patient Participation Group (PPG) at the practice. They said they had attempted to re-establish a group in early 2019 but this wasn't successful. At the time of our inspection, the focus was on identifying patients who may be interested in moving this forwards.	

We saw there were other methods available for patients to express their views and leave feedback about their experiences including a suggestions box in the practice. The relevant staff we spoke with told us most patients chose to feedback or provide suggestions directly with staff and the practice encouraged this as a way of responding to patients. There was no online comments facility available through the practice website. The website was basic, and some information was out-of-date.

The practice had an effective system in place for handling complaints and concerns. Information was available to help patients understand the complaints system. Complaints notices were displayed around the practice in all the waiting areas and a leaflet detailing the complaints process was available from reception. The complaints procedure was available on the practice’s website, although this contained out-of-date information. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care or patient experience.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<p>The practice was a GP training practice and maintained high standards for supporting its trainees. One of the GPs was a qualified GP trainer and one GP was completing the qualification.</p> <p>There were plans for the clinical pharmacist directly employed by the practice to complete a diploma in diabetes care. One of the GPs at the practice was investigating and trialling ways to optimise care for patient with diabetes and the clinical pharmacist would join this effort.</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 practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

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

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

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

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

Glossary of terms used in the data.

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