

Inspection Evidence Table

Chorlton Family Practice

(1-544250271)

Inspection Date: 12 January 2024

Overall rating: Requires Improvement

We carried out a comprehensive inspection at Chorlton Family Practice, Chorlton-cum-Hardy, Manchester on 12 January 2024. We attended the main site and also the branch practice located at Corkland Road, Chorlton-cum-Hardy. We rated the key questions safe, responsive and well led requires improvement and effective and caring as good. This resulted in the service being rated requires improvement overall.

Context

Chorlton Family Surgery is located within the Greater Manchester Care Partnership and NHS Greater Manchester Integrated Care Board. They want people across all boroughs to stay well and bring together different organisations that support people's health and social care.

Information published by the Office for Health Improvement and Disparities shows that deprivation within the population group is 5 (5 out of 10). The higher the decile the less deprived the practice population is relative to others. According to the latest available data, the ethnic make-up of the practice area is 68.6% white British, 17.7% Asian 4.9% Black, 5.3% mixed and 3.5% other.

The practice has struggled with GP recruitment and loss of staff following mergers over the last twelve months which has had a negative impact on safety and governance. They initiated their own internal investigations and were on a journey of recovery and improvement at the time of the inspection. There is currently no permanent practice manager but the practice have increased duties of other staff to cover practice management until March 2024.

Safe

Rating: Requires Improvement

We have rated the practice as requires improvement for providing safe services because recruitment checks and staff vaccinations had not been maintained appropriately. Health and safety assessments did not identify all potential risks. There was mixed feedback from staff about how absence and staffing levels were managed. The system to report and manage significant incidents was not robust. The practice had undertaken their own internal investigation into these and other matters prior to the inspection process and were still in the process of making improvement.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse. We saw the safeguarding policy and staff were able to tell us who they would go to if they wished to raise safeguarding concerns.• There was a safeguarding lead, deputy and administration role.• Staff had access to safeguarding e-learning modules and all staff had completed safeguarding training to the appropriate level for their role. We noted that staff were prompted to ensure all mandatory training was completed immediately prior to the inspection.• We saw evidence of regular monthly meetings where patients were discussed and the safeguarding registers were kept up to date.• As the result of an internal investigation undertaken by the practice themselves, a consultant practice manager was recruited to provide support to the practice from October 2023. They identified that DBS checks were not in place for all staff. We saw that action had been taken and at the time of the inspection all DBS checks had been undertaken where required.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had identified gaps in the staff recruitment and immunisation records and had a plan in place to complete them.	

- We were informed by the practice management staff that full up to date HR records had not been available for all staff. Improvements in record keeping had been started but at the time of the inspections there were still gaps. This was mostly around record keeping and ensuring that all documentation was available in one place where it was easily identifiable. We were assured from our review of personnel records that this piece of work was ongoing and the essential requirements such as job descriptions, references, safeguarding checks and right to work checks were appropriately undertaken for staff.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Partial
Date of last assessment:	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: 23/6/2023 and 27/11/2023	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • NHS property services were responsible for fire safety at the premises in Nicolas Road and the practice received copies of risk assessments and any actions from them. However separate arrangements were required for the premises at Corkland Road. • We saw evidence that actions from the fire risk assessment in November 2022 for Nicholas Street were completed. We were told there were no actions from the latest assessments. • Fire alarm checks were carried out at both premises on a Monday morning and fire training was completed via e-learning. Face to face fire safety had also been arranged. • Separate arrangements were in place for Corkland Road and we saw evidence of a fire risk assessment being completed by an external company in August 2022. The consultant practice manager undertook an internal assessment in November 2023 with no actions identified. • Health and Safety assessments were completed for both premises. However, the assessment did not pick up all risks. For example, at Corkland Road, window blinds in a clinical room did not have cleats to hold the chains in place or breakaway clips to break the chain if they were pulled. They had not been risk assessed and therefore could present a hazard. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit: 13/11/2023	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence:	

- There was a lead nurse responsible for infection prevent and control and staff were aware of her role and responsibilities.
- Staff completed appropriate training via e-learning.
- An appropriate audit which evidenced action required had been undertaken and was in review at the time of the inspection.

Risks to patients

There were gaps in 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.	Partial
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Staff feedback was mixed with regard to the practice approach to managing staff absences and busy periods. Some staff we spoke to felt the practice would benefit from more clinical and more administration staff. Feedback in staff questionnaires corroborated this. 	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes

There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients. For example, in the records that we reviewed, history, examination, management plans, safety netting and follow up were adequately documented within the patient record. We were alerted to patient records where concerns had been pointed out. We saw that these had been dealt with under internal investigation. 	

Appropriate and safe use of medicines

The practice had / did not have systems for the appropriate and safe use of medicines, including medicines optimisation.

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2022 to 30/09/2023) (NHSBSA)	0.54	0.98	0.91	Variation (positive)
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). (01/10/2022 to 30/09/2023) (NHSBSA)	7.5%	7.9%	7.8%	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 (01/04/2023 to 30/09/2023) (NHSBSA)	4.91	4.98	5.19	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2023 to 30/09/2023) (NHSBSA)	101.1‰	169.3‰	130.7‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2022 to 30/09/2023) (NHSBSA)	0.28	0.74	0.53	Tending towards variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2023 to 30/09/2023) (NHSBSA)	4.8‰	7.3‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
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The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> The clinical searches identified a total of 58 patients taking medicines for the management of hypertension, cirrhosis, and congestive heart failure. Of those we identified 7 patients who appeared to be overdue appropriate monitoring. We sampled 5 of those and found that there were no problems with the care of patients and that appropriate blood tests were being carried out to ensure there were no concerns. The clinical review of patients' records identified that medicines reviews were carried out. The reviews were appropriately documented, addressing required monitoring or changes to treatment. The clinical review of patients' records identified no concerns with the monitoring of high risk medicine. The provider was able to demonstrate that it remained safe to prescribe medicines to patients where specific, frequent, monitoring was required. Where patients were having blood tests arranged via the hospital we saw that this was routinely recorded. 	

Track record on safety and lessons learned and improvements made.

The practice mostly learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	9
Number of events that required action:	9
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There was a system in place to report and manage significant incidents and staff we spoke to told us they understood the system, and when and how to report incidents. However, we found evidence that this was not always the case. We discussed this with the practice during the inspection. Systems were in the process of being reviewed and updated since the departure of the previous practice manager. We found investigation details and actions were not fully documented and there was no central recording system for incidents that could be accessed easily by all staff. This was under review at the time of inspection. 	

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

Event	Specific action taken
A delayed test was identified 8.11.23 due to a sample processing error. Multiple contacts, issues with FIT test sampling and repeat test filed as abnormal but not actioned as 2WW. Misfiling in document management system by GP. Sample processing error	Discussion around continuity of care and urgent results must be actioned by whoever receives. The practice encouraged reviews with same GP for continuity. Processes were reiterated to remind patients that tests were required. We saw evidence of review in the practice meeting on 13 December. However, it was unclear what specific actions and checking systems, other than informal discussions were in place or had taken place to ensure the process was failsafe and this did not reoccur. A completion date of January 2024 was given. Staff learning identified.
A suicide was identified in August 2023. Not preventable. Clinical incident	Revisit and revise Patient in Crisis protocol and add to Half Day Closing agenda. MH training for Urgent care team/other clinicians.

	<p>We saw this was discussed at the practice meeting in November 2023. However, it was unclear from the documented notes what, if any, specific learning had been taken from the incident as there were question marks around this, or whether the training had been undertaken/completed.</p> <p>Staff learning identified and discussed in practice meeting.</p>
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We saw examples of actions taken on recent alerts, for example, SLGT2 inhibitors (a medicine used to lower blood glucose levels). We found evidence to confirm the clinician prescribing the medication had discussed the risks and potential side effects of the medicine for most patients. 	

Effective

Rating: Good

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Yes

We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated. ³	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Yes
The practice prioritised care for their most clinically vulnerable patients.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • During the onsite inspection we discussed with staff the way in which patients' needs and ongoing care were assessed, including their clinical, mental and physical wellbeing. Staff demonstrated how patients could be signposted to social prescribers and other first contact providers within the network for support. • We saw there was an appropriate system in place for onward referrals to secondary services including 2 week wait referrals and patients were followed up in a timely and appropriate way. • The clinical searches identified no concerns in relation to the management of patients with diabetes. We identified 19 patients that may benefit from a diagnosis of pre-diabetes to ensure any required monitoring took place. We reviewed 5 of those and found 2 potential cases for review. We discussed these with the practice. • We looked at patients with asthma that required follow up within one week of receiving a steroid. We found minor concerns which we discussed with the practice. A quality improvement project was already being undertaken in this regard and a new policy was being implemented. • There were no concerns with the management of patients with chronic kidney disease. • The clinical searches identified 12 patients out of 615 on thyroid replacement medicines who may not have had a monitoring blood test in the last 18 months. We reviewed 5 patient records and found 4 were overdue. 	

Effective care for the practice population

Findings
<ul style="list-style-type: none"> • The clinical searches identified that patients received a full assessment of their physical, mental and social needs. Elderly patients were triaged and prioritised by reception staff and an encounter was provided on the same day for a clinician to deal with. • Health checks, including frailty assessments, were offered to patients over 75 years of age. Opportunistic health checks and frailty assessments were also offered. 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. • Elderly patients on palliative care were identified to ensure their needs were met. Monthly Gold Standard Framework meetings were held. The practice fostered good working relationships with the district nursing team, social prescribers, and care co-ordinators along with any wider network. Through this multidisciplinary approach they worked closely to support patients in residential homes and home visits. • We spoke with the manager of the residential home who provided positive feedback.

- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- The clinical review of patient records identified that patients' ongoing long term condition needs were fully assessed.
- The clinical examination of patient records identified that patients were appropriately followed up.
- Patients with long term conditions were reviewed to ensure their treatment was optimised in line with national guidance. We reviewed samples of patients with asthma, diabetes and chronic kidney disease and found they were all well managed.
- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	241	259	93.1%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received	244	272	89.7%	Below 90% minimum

Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)				
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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	246	272	90.4%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	249	272	91.5%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	230	268	85.8%	Below 90% minimum

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
<ul style="list-style-type: none"> The practice was aware they had not reached the World Health Organisation target of 90% for child immunisations which was in part attributable to the cultures of the practice population. They continued to encourage parents and educate them about the benefits of immunisation which was an ongoing task.

Cancer Indicators	Practice	SICBL average	England	England comparison
Bowel cancer screening coverage: aged 60 to 74 years old (01/04/2022 to 31/03/2023) (UKHSA)	67%	N/A	72%	N/A
Breast screening coverage: aged 53 to 70 years old (01/04/2022 to 31/03/2023) (UKHSA)	60.1%	N/A	66.6%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	50.0%	54.3%	54.9%	No statistical variation
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (6/30/2023 to 6/30/2023) (UKHSA)	70.3%	N/A	80.0%	Below 80% target

Any additional evidence or comments
<ul style="list-style-type: none"> The practice was aware their uptake for cervical screening was below the target of 80% which was in part attributable to the cultures of the practice population. We spoke with one of the practices nurses who explained how the practice encouraged uptake opportunistically.

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.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
<ul style="list-style-type: none"> We saw evidence that the practice had a quality improvement programme and we reviewed the most recent two-cycle audits that had taken place. Examples of quality improvement included the management of long term conditions, and specifically a quality improvement project around asthma management. Flexibility of appointment times was maintained by the practice and the practice had undertaken several reviews to ensure that patients were receiving an optimum service. 	
Any additional evidence or comments	
<ul style="list-style-type: none"> The practice had identified areas of concern and of their own fruition had undertaken an internal investigation. They had sought help from the Royal College of General Practitioners (RCGP), a practice manager consultant one day a week, and other external sources. It was very apparent from the inspection process that they were taking the concerns seriously and were positive about learning and improving going forward. The inspection identified that some improvements were still required, but it was evident that any major risks to patients had been mitigated. 	

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes

There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Immediately prior to the inspection all staff were encouraged to complete any outstanding mandatory training. We saw that staff had been provided with flash cards for easy reference to things such as sepsis management, safeguarding and infection control. 	

Coordinating care and treatment

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice was able to demonstrate effective communication with other organisations such as the out of hours service, the residential home, health visitors, charitable organisations, social prescribers and other voluntary organisations to ensure the best possible interventions for patients. 	

Helping patients to live healthier lives.

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

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

- Social prescribing staff within the primary care network helped patients with personal and social concerns.
- Gold Standard Framework (GSF) meetings were held monthly to ensure patients received the most appropriate care at the end of their lives.
- The practice promoted champions and held a chatty café, crafty corner and weekly walks for patients. They had relationships with Chorlton Good Neighbours for the benefit of patients and also locality community teams which were located in the same building.
- They worked with the Real Food Group in Chorlton to promote diet-focused diabetes care. There was a community diabetes team to support the large population of people with diabetes. We also saw a food bank in the reception area.
- They promoted clean air initiative.
- They promoted a social club (the Leg Club) for people with poor circulation and leg ulcers.

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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
<ul style="list-style-type: none"> • The practice had an established process for DNACPR reviews. There was a register for all patients on palliative care to ensure their needs were met. Multidisciplinary GSF meetings with district nurses, and end of life/GP lead representative were held where patient care was regularly reviewed and updated as appropriate. Families and carers were involved in formulating care plans including DNACPR status, statement of intent and the issuing of any anticipatory medicines. 	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was mixed about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

Explanation of any answers and additional evidence:

- During the onsite inspection we spoke with staff and observed the way patients were treated and spoken to when they attended or telephoned into the surgery. We saw that all patients were spoken to kindly and with respect.
- Language line services were offered for those patients who did not speak English.

Patient feedback	
Source	Feedback
CQC enquiries	In the previous 12 months CQC received concerns about the practice from 11 patients who were dissatisfied with the care and treatment they had received.
NHS Feedback	52 responses on the NHS Website were reviewed. There were 10 rated as 5 star, 8 as 4 star, 8 as 3 star, 7 as 2 star and 18 rated 1 star.

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
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 listening to them (01/01/2023 to 30/04/2023)	84.7%	85.4%	85.0%	No statistical variation
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 (01/01/2023 to 30/04/2023)	85.9%	84.4%	83.8%	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 (01/01/2023 to 30/04/2023)	94.0%	92.2%	93.0%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	63.0%	71.2%	71.3%	No statistical variation

Any additional evidence or comments

- The practice identified that the 2023 patient survey highlighted several significant areas for improvement. Some of those were covered in their capacity and access plan, but more work was identified to engage with the community and better understand how they would access the practice.
- 466 surveys were issued, 124 were returned, and there was a completion rate of 27%. The practice scored well on continuity, that the healthcare professional listened to the patient (85%), giving patients

enough time (83%), confidence in the health care practitioner (HCP) (94%), treating the patient with care and concern (86%).

- The practice scored less well on overall experience (63%), and all access metrics. Areas were identified for improvement more around access.

	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Yes

Any additional evidence

- The practice intended to repeat their own patient survey later in the year following the internal audit of their own processes and produce a structured engagement plan with their patient population in mind to better understand how needs were met.
- There was a hope to be able to access local development funding to support those improvements. In 2024/25 there was a plan to focus on continuity of care and conduct internal work to improve internal processes for administration staff and those booking appointments.

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.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had access to two focused care workers (similar to social prescribers) and one assistant who could help patients and their carers to find further information and access community and advocacy services. There were also social prescribers and practice champions to assist with queries. 	

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	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 (01/01/2023 to 30/04/2023)	83.6%	89.1%	90.3%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We saw a myriad of information in the reception area to help patients with things that were going on in the surgery and in and around the local community. 	

Carers	Narrative
Percentage and number of carers identified.	553 patients were denoted on the clinical system as carers. This equated to more than 2% of the practice population.
How the practice supported carers (including young carers).	There was GP clinical lead who supported the carer's register. Carers were offered advice and had access to appointments for health checks and immunisations.
How the practice supported recently bereaved patients.	The practice website signposted patients to suicide bereavement services and also the Greater Manchester Bereavement services for help and support.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> While on site we saw a patient being offered the choice of a private room to discuss their issue properly away from others waiting at reception. 	

Responsive

Rating: Requires Improvement

We recognise the pressure that practices are currently working under and the efforts staff are making to maintain levels of access for their patients. At the same time, our strategy makes a commitment to deliver regulation driven by people's needs and experiences of care. Although we saw the practice was attempting to improve access, this was not yet reflected in the GP patient survey data or other sources of patient feedback.

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.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
Explanation of any answers and additional evidence:	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 8.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	8am – 8.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm

Further information about how the practice is responding to the needs of their population

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- Patients had a named GP who supported them in whatever setting they lived.
- 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 liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Additional nurse appointments were available until 7pm on a Monday for school age children so that they did not need to miss school.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- According to the website extended hours access clinics were available Monday – Friday until 8.30pm, on alternate Saturdays between 08.30am – 11am and on Sundays between 08.30am – 2.30pm.
- Also according to the website there was no telephone access after 6:30pm on any weekday or during the weekend. The website however, was open from 7am each day for access for working people. It was also open from 7am until 12 noon and then from 1pm until 4pm. Telephone access was recommended between 12 noon and 1pm and then after 4pm, or if the website was closed early due to demand.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Partial
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Yes
Patients were able to make appointments in a way which met their needs.	Partial
There were systems in place to support patients who faced communication barriers to access treatment (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised.	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice identified from the GP patient survey that only 38% found it easy to get through to the practice by telephone. By the end of January 2024 they planned to upgrade to a cloud-based telephone system which would have automated call back features and queuing updates to reduce frustration and improve workflow. • There were also plans to implement a system to stream patients from a call queue and provide other ways to communicate via the website such as website forms for routine appointment requests. • Staffing levels were being optimised during peak call times and patients were being reminded that website access was available from 7am. 	

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	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 (01/01/2023 to 30/04/2023)	38.0%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	40.9%	55.2%	54.4%	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 (01/01/2023 to 30/04/2023)	36.5%	56.2%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	47.6%	71.0%	72.0%	Variation (negative)

Any additional evidence or comments

- The GP survey data was substantially lower than national and local averages. Although the practice was trying to make improvements some things were aspirational for the future and overall there was no evidence as yet that the changes made had impacted positively on patient experience.
- The practice was awaiting confirmation of funding from the GP improvement programme to enable them to engage professional external review of urgent care pathways for clinical and admin staff.
- There was further training to triage appointments effectively to direct patients to the most appropriate healthcare professionals and streamline online forms and SMS contacts for non-urgent cases.

Source	Feedback
NHS.uk website (formerly NHS Choices)	52 responses were reviewed from the NHS website. 33 were negative and were 3 stars or lower.

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.	22
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	4
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Example(s) of learning from complaints.

Complaint	Specific action taken
Administration/reception complaints example: Staff did not always make an entry in the patient notes after contact.	Management team reminded staff of existing protocols to be followed. Every record entry should be recorded under the correct category.
Prescription errors example: Delays in issuing prescription following discharge from hospital due to delay in letter being processed in the document management system.	Management team reminded staff of importance of keeping up to date with document management and reminded of protocol to follow.
Clinical complaint example: Unhappy with consultation with advanced nurse practitioner and GP.	The complaint was investigated. Discussions with the clinicians involved. Telephone calls listened to and notes reviewed. Learning needs discussed, communication skills highlighted.

Well-led

Rating: Requires Improvement

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

We have rated the practice as requires improvement for providing well led services because staff feedback was mixed regarding visibility and approachability by leaders. The governance structures and systems were unstable whilst awaiting the permanent employment of a new practice manager. The arrangements for identifying, managing and mitigating risks were not robust and although improvements had been identified they were not embedded.

	Y/N/Partial
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Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The provider had identified challenges to the quality and sustainability of the practice and had commissioned an independent review. The provider was working through an action plan to address the concerns and issues identified. At the time of the inspection there was no practice manager in post and duties were shared between the office manager and partners. Feedback from staff included positive and negative responses about the visibility and approachability of leaders. Not all staff felt that same although most reported that improvements were evident. 	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> It was evident that leaders and staff we spoke with were aware of the journey of improvement that the practice was on. Staff told us that improvements had been made. The practice endeavoured to provide a first class service at all times whilst accepting that sometimes things could go wrong. They stated that they promoted a culture that was open and honest and a policy that applied to all their team. 	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Partial
There was a strong emphasis on the safety and well-being of staff.	Yes

There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Prior to the inspection we received information from staff past and present. Not all staff felt able to raise concerns that would be listened to. However, staff we spoke to on the day of the inspection said the culture had changed for the better since the need for improvement had been identified. This culture needed to be embedded. 	

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

Source	Feedback
Information received by CQC prior to the inspection.	Negative whistleblowing concerns
Staff questionnaires	<p>Positive and negative feedback was received such as not being invited to meetings where significant incidents were discussed. However, information was shared afterwards. 4 members of staff said they were not made aware of any complaints but did have the opportunity to attend meetings if workload permitted. We were told that better support and communications from managers and leaders would be welcomed. Some staff felt understaffed and overworked and that morale was an issue but this was improving. Staff would welcome an inclusive culture and fairness across all groups. Some staff felt they were not involved in discussions and just got told when things changed. Concerns were not always accepted or listened to.</p> <p>Staff said they were invited to monthly meetings but were often unable to attend due to high workloads. Minutes were shared afterwards.</p> <p>Clinical staff reported clear policies on prescribing which was good for difficult cases.</p> <p>Better leadership and communications was highlighted as a desire for improvement.</p>
Speaking with staff	We spoke to staff on site who reported they were very happy working at the practice. They felt that managers and leaders were visible and they would feel listened to if they raised any issues or concerns. We were given examples where staff felt personally supported, that risks were identified, that staffing levels were addressed and that the overall culture was improving.

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.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Yes
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice had been through a period of turmoil when there had been a merger with another practice, senior practice staff had left or resigned, and an internal investigation had been carried out. This had inevitably caused disharmony and unease within all areas. The governance structures were under review but the permanent practice manager was not yet in post and the practice was unable to demonstrate that all areas identified for improvement were fully embedded.	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">We saw that risks and issues were mostly well managed since the internal investigation. However, there were still gaps. For example, we saw that health and safety risk assessments did not identify all areas where risk may be an issue and the practice was not able to evidence that all staff reported incidents or responded to incidents in line with the practice policy.	

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to monitor and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	No
<ul style="list-style-type: none"> We were made aware of an incident prior to the inspection process that had not been reported to CQC as required by legislation. 	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Staff are supported to work remotely where applicable.	Yes

Engagement with patients, the public, staff and external partners

The practice did not entirely involve 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.	Partial
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Partial

The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Feedback was that the patient participation group did not reflect the views of the patient population and was limited to a smaller group. Feedback during discussions with staff and from questionnaires received was mixed about how their views were highlighted, listened and/or responded to. 	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice submitted a number of clinical audits prior to the inspection and we saw that these were ongoing and reflected learning and improvement in clinical and managerial areas. There were gaps in the system for reporting significant incidents. 	

Examples of continuous learning and improvement

<ul style="list-style-type: none"> The practice had identified areas of concern and had undertaken an internal investigation. They had sought help from the Royal College of General Practitioners (RCGP), a practice manager consultant one day a week, and other external sources. It was very apparent from the inspection process that they were taking the concerns seriously and were positive about learning and improving going forward. The inspection identified that some improvements were still required, but it was evident that any major risks to patients had been mitigated.

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 persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for those aged 25 to 49, and within 5.5 years for those 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.
- **UKHSA:** UK Health and Security Agency.
- **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.
- ‰ = per thousand.