

Care Quality Commission

Inspection Evidence Table

Greenlands Surgery (1-9213530005)

Inspection date: 19 May 2022

Date of data download: 17 May 2022

Overall rating: Good

We inspected the practice on the 16 and 19 May 2022. The practice is rated Good in the effective, caring, responsive and well-led key questions. The practice is rated Requires Improvement in the safe question.

This is because:

- Recruitment policies and procedures were not fully implemented for all staff and not all recruitment checks had been completed.
- Oversight of the practice's Medicines and Healthcare products Regulatory Agency (MRHA) alerts system was not being operated effectively.
- The practice's systems for the appropriate and safe use of medicines in relation to prescription management and maintenance of the cold chain were not effective.

Safe

Rating: Requires Improvement

Safety systems and processes

The practice did not have 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.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y (1)
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	P (2)
Disclosure and Barring Service (DBS) checks were undertaken where required.	P (3)

Safeguarding	Y/N/Partial
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>(1) The practice had up to date policies relating to safeguarding vulnerable adults and children; a GP partner was the named lead. The practice participated in monthly Multi-Disciplinary Team meetings, with other relevant agencies, where safeguarding cases were discussed and reviewed.</p> <p>(2) Staff placed safeguarding alerts on to the records of potentially vulnerable adults and children to alert clinicians. However, alerts were not always entered onto the records of any parents or guardians of children with safeguarding concerns. We raised this as a concern to the practice as part of our inspection, and saw the practice took immediate action to rectify this.</p> <p>(3) We looked at recruitment files for four staff and found DBS checks had been obtained for all four. However, we were not assured that DBS checks obtained for two members of staff during the pandemic had been reviewed appropriately. Following the inspection, evidence was provided that all recruitment records had been audited and a new recruitment check list put in place.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N (1)
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <p>(1) Recruitment policy and procedures were in place and had been updated in April 2022 and included requirements relating to references, Disclosure and Barring Service (DBS checks) and employment contracts. However, this policy and procedure had not been fully implemented and not all the required checks and records had been completed for all staff.</p> <p>For example, we reviewed the records for four staff (two clinical and two non-clinical). We found references had not been obtained for two members of staff; the recruitment file for a third member of staff contained only one reference and the second reference for the fourth member of staff had been obtained from an employer not detailed in their employment history. There was no contract and terms and conditions for one member of staff or interview summaries for two members of staff.</p> <p>Following the inspection evidence was provided that the practice had audited the staff recruitment records, completed a recruitment check list and obtained/completed the outstanding checks and records.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: February 2022	P (1 and 2)
There was a fire procedure.	Y
Date of fire risk assessment: 6 May 2022	P (1 and 2)

Actions from fire risk assessment were identified and completed.	
Explanation of any answers and additional evidence:	
<p>(1 and 2) Comprehensive risk assessments had been completed for areas such as Legionella control; fire safety and health and safety by external agencies. Action plans identified works to be completed and the practice manager gave assurances the majority of improvements had been completed either by contractors or the practice staff, however, there were limited records to demonstrate this.</p> <p>(1 and 2) The individual responsibilities of each practice within the medical centre was not made clear in the action plans, where shared improvement work was required in relation to the building. Following the inspection, evidence was provided that the majority of all improvement work identified from the risk assessments had either been completed or was scheduled.</p>	

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.	Y
Infection prevention and control audits were carried out.	
Date of last infection prevention and control audit: Main surgery: September 2021 and Branch Surgery: August 2021.	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<ul style="list-style-type: none"> Audits had been completed by North East Lincolnshire CCG infection prevention and control team at both surgeries. The main surgery scored 100% and the branch scored 98%; one minor area for improvement had been identified and actioned. The Practice Nurse was named lead for infection prevention and control (IPC) matters and completed monthly IPC audits. The practice had taken several precautionary measures and made several changes to their service to keep patients and staff safe during the COVID-19 pandemic. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y

Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y

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
Referrals to specialist services were documented, contained the required information 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

Appropriate and safe use of medicines

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

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) (01/01/2021 to 31/12/2021) (NHS Business Service Authority - NHSBSA)	0.75	0.90	0.76	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). (01/01/2021 to 31/12/2021) (NHSBSA)	4.5%	8.8%	9.2%	Variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r	5.56	5.66	5.28	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2021 to 31/12/2021) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	50.6‰	163.7‰	129.2‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) (NHSBSA)	0.52	0.59	0.62	No statistical variation
(to) (NHSBSA)		-		-

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	P (1)
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y (2)
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 and Improvement 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.	NA
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

Medicines management	Y/N/Partial
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.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y (3)
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	P (4)
<p>Explanation of any answers and additional evidence:</p> <p>(1) Although the practice stored all blank prescriptions securely, access to non-designated staff was not adequately controlled. The practice held records of when new blank prescriptions were delivered and when they were assigned to a specific prescriber, but the process did not allow for effective reconciliation and tracking of blank prescriptions. Not all prescriptions supplied to the branch surgery had been recorded. Following the inspection, we received evidence the provider had introduced a new prescription tracker and protocol.</p> <p>(2) As part of the inspection, we undertook a series of remote searches of the practice's clinical records system to review procedures around medicines management and prescribing. Although we found most patients received appropriate reviews for their condition/and or medicine, there were a small number of examples where a review had not taken place within the recommended timeframe. In some cases, we were told patients had been reluctant to attend the practice. Where patients were receiving specialist secondary care, relevant records had not always been downloaded to the clinical records system.</p> <p>A search identifying patients prescribed a high-risk medicine primarily used to treat mood disorders showed one patient was prescribed the medicine and overdue the recommended monitoring, which was completed after the inspection.</p> <p>A search identifying patients prescribed a high risk medicine primarily used to treat hypertension and heart failure showed of the 238 patients prescribed the medicine only 3 patients had not had a review, although their review status had been recognised. This showed the monthly searches completed by the GP's supported positive medicines management in this area.</p> <p>A search identifying patients on particular medicines in combination (a medicine to prevent blood clot formation and a medicine to reduce stomach acid), which had been identified in a medical alert, showed five patients had been prescribed these medicines and three of the patients for a significant amount of time. Although all patients' prescriptions had recently been reviewed and changed, previous reviews and searches had not identified the risk.</p> <p>(3) Although the practice held its own emergency medicines and defibrillator, arrangements were in place to share access to emergency oxygen with two other practices in the same building. Staff were aware of the location of each item and had completed an exercise to assess access to this equipment and their response in an emergency. There was no risk assessment in place in relation to oxygen storage and this was provided after the inspection.</p> <p>(4) Vaccines which required refrigeration were stored securely in lockable fridges. Records showed there were gaps in the daily monitoring of the temperatures, although there had been no anomalous recordings. In discussions, staff were not clear about some aspects of the functionality of the new fridge, and all action to take if there was any disruption to the cold chain management. Following the inspection, we received evidence the provider had introduced a new record for monitoring the fridge temperatures and ensured a copy of the cold chain policy was readily accessible for</p>	

Medicines management	Y/N/Partial
designated staff. The practice manager intended to discuss the policy with staff at the next practice meeting.	

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: Five	Y
Number of events that required action: Five	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Staff knew the process for reporting incidents. • All incidents were discussed at clinical and practice meetings, with any learnings shared with all practice staff. 	

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

Event	Specific action taken
Medication prescribed to patient although medication had been stopped by the hospital.	Prescription cancelled. Information received from the hospital about medicine changes will be actioned upon receipt and patients' records to be updated.
Patient referred for secondary care, but referral not received by hospital.	Referral re sent. All referrals sent via courier will be recorded and patients will be contacted after four weeks to check if they have received information/ an appointment from the hospital.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	P (1&2)
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: <ol style="list-style-type: none"> (1) We saw evidence in meeting minutes of dissemination and discussion of safety alerts affecting the practice. The practice manager explained the procedure followed when safety alerts were received, however there was no audit trail of actions taken. (2) The systems for ensuring historic safety alerts were still followed, where appropriate, required strengthening. We found a small number of patients prescribed a combination of medicines that 	

was the subject of a previous safety alert. The medicines prescriptions had recently been reviewed and changed. However, further work was required to ensure previous safety alerts were checked for on a regular basis. Following the inspection, evidence was provided that the practice had introduced a new safety alert recording system.

Effective

Rating: Good.

QOF requirements were modified by NHS England 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.	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 had prioritised care for their most clinically vulnerable patients during the pandemic	Y
Explanation of any answers and additional evidence: GPs had attended seminars regarding changes to guidance, with discussions held with other clinicians and pharmacists and provided feedback to the practice. A local practice had lead responsibility in the PCN for reviewing the use and implementation of guidance issued by the National Institute for Health and Care Excellence (NICE) to ensure care was provided in accordance with current evidence-based practice. This was shared with the practice and new guidance was reviewed at clinical meetings.	

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- 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 29 patients with a learning disability on the register. All patients with a learning disability were offered an annual health check. 28 of the 29 patients had had a health review in the last 12 months. One patient had refused the health check and the practice had referred them to the community team for follow up.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. This included joint working with palliative care teams, charitable organisations and the local hospice.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- Patients with long-term conditions were mostly offered a structured annual review to check their health and medicines needs were being met.
- As part of our inspection, we conducted a series of searches on patient records to review the practice's procedures for the management of patients with long term conditions:
- One search reviewed the monitoring of patients with a thyroid condition who had not had a thyroid function test in the last 18 months. Our search identified eight patients who had not received an appropriate test within this period. We reviewed five of these patients records and found alerts had identified overdue monitoring. The provider explained some patients were declining the review and they would assess the management of this.
- Another search reviewed the monitoring of patients with chronic kidney disease at stages four or five. Our search identified two patients who were coded as having this diagnosis but who did not receive all required monitoring tests. However, we noted one patient was also under the care of a renal specialist and their results could be downloaded to the system.
- A third search reviewed the recording of patients diagnosed with diabetic retinopathy; a complication of diabetes caused by high blood sugar levels. Our search identified 12 patients whose last blood sugar test showed high sugar levels. We undertook a detailed review of five

patients' records, which showed all patients had received a medication review and four had received diabetic review within the last 12 months. One patient's latest blood test results were not in the normal range which should have triggered a referral to secondary care. Following the inspection, the provider confirmed this had been completed.

- Another search reviewed the management of patients with asthma who had been prescribed two or more courses of rescue steroids within the last 12 months. Our search identified nine patients who had been prescribed two or more course of rescue steroids. We undertook a detailed review of five patients' records, which showed all but one patient had received an annual asthma review within the last 12 months. There was some inconsistency in the quality of recording the reason for prescribing the rescue medicine and detail of symptoms. One patient had not been issued with a steroid card, which provides patients and healthcare professionals with instructions on how to manage their condition in an emergency.
- A final search reviewed patients with a potential missed diagnosis of diabetes. Our search identified one patient was not appropriately coded on their records and following our inspection, the provider confirmed they had addressed this.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example, diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	30	34	88.2%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	33	33	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and	32	33	97.0%	Met 95% WHO based target

Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)				
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	32	33	97.0%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	36	40	90.0%	Met 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

- We noted the immunisation rates were slightly below target for children aged one and discussed the results with practice staff. The cohorts were small, and the rates were easily influenced by a few families not taking up immunisations. Patient record systems had alerts to show overdue immunisations and practice staff followed this up.

Cancer Indicators	Practice	CCG average	England average	England comparison
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). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	76.1%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	64.3%	39.9%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	68.6%	62.9%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	45.5%	47.8%	55.4%	No statistical variation

Any additional evidence or comments

- The practice's performance on the above cervical screening indicator was slightly below the 80% target. The practice worked opportunistically to engage with patients attending routine appointments, or otherwise made contact, to check if they had had the screening completed elsewhere, wished to decline the procedure or make an appointment.

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.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	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

- Records showed the practice had completed 12 clinical audits in 2022. We reviewed two clinical audits submitted by the practice.
- An audit on the prescribing of Co-Cyprindiol (a medicine for the treatment of acne) in May 2022 showed improvement actions had been implemented from the first cycle audit, with positive results. Far fewer patients were prescribed this medicine, it was not on repeat prescription and not prescribed for longer than 6 months. This was in line with the new prescribing policy to maintain patient safety due to the risk factors associated with this medicine.
- The audit of Orlistat (a medicine for weight loss) in May 2022 was completed to ensure all patients prescribed the medicine met the National Institute for Health and Care Excellence NICE guidelines for initiation and continued treatment. This showed improvement actions had been implemented from the first cycle audit with mixed results. All patients met NICE guidelines, however poor compliance with weight management was identified which the clinician will discuss with all new patients before prescribing, as the medicine is only continued after three months if the patient has lost 5% of their initial weight.

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.	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
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: <ul style="list-style-type: none"> • New staff completed an induction programme. An on-line training package was available to staff and a training plan in place. • The GP's, practice nurse and health care assistant discussed new guidance and new cases at monthly clinical meetings. They had protected learning time each month through the PCN and recent training sessions included diabetes updates and new innovations in the diagnosis and management of patients with asthma. • Staff had appraisals and access to regular support. 	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice was part of a GP Federation of 15 practices with a combined total of 47,000 patients. They worked together to provide access to additional services such as a pharmacist and a first contact physiotherapist. They had also worked together to implement a project to deliver a consistent GP service to care homes and support patients with chronic and complex needs. 	

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 and tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice provided monitors at both surgeries for patients to measure their own blood pressure and body mass index (BMI). People had open access to the equipment which supported involvement and independence whilst helping reduce the pressure on the practice nurse and health care assistant. The practice worked closely with Thrive, the local health and wellbeing social prescribing service and referred patients there for additional advice and support. For support with mental health and emotional wellbeing, patients were signposted to the Open Minds talking therapy service. Young people were signposted Young Minds Matter and to Kooth. Staff from the Department of Works and Pensions had recently set up a clinic in the practice building to provide support for people who were on long term sick leave. 	

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
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Patients and their relatives were involved in care and treatment decisions, including any discussion regarding end of life care. A review of patients' notes showed DNACPR decisions had been concluded and recorded appropriately. 	

Caring

Rating: Good

Kindness, respect and compassion

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

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

Patient feedback	
Source	Feedback
CQC Website: Share Your Experience	Feedback from patients as part of our inspection was very positive. Patients were very satisfied with the quality of care and service they received. They considered appointments and referrals were arranged quickly and results discussed. Patients also felt staff were always helpful and available. They described staff as, "The best they have had", "Lovely and kind" and "Everyone knows me and looks after me."
Google Reviews	In the 12 months prior to our inspection, nine reviews were posted. Eight reviews contained very positive comments about staff working at the practice, good access arrangements and the high standards of care and service they received. One review contained negative information about limited access at the branch surgery.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	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 (01/01/2021 to 31/03/2021)	94.3%	87.0%	89.4%	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 (01/01/2021 to 31/03/2021)	94.7%	87.7%	88.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	96.6%	94.7%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	90.8%	83.0%	83.0%	No statistical variation

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

Any additional evidence

- Patients had been surveyed in April 2022 and all the feedback was positive.
- Improvements made from previous survey feedback included: new BP/ BMI monitors at both surgeries; additional ways of contacting the practice via on line and messaging services and an in-house contraceptive service.

Involvement in decisions about care and treatment

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

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

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	94.9%	92.2%	92.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had a variety of information on display in the waiting area regarding local services, including mental health services and bereavement counselling. Information was available to patients in different languages. Staff were able to use translation services to help patients whose first language was not English. There were some staff at the practice who were able to speak some of the languages of the more ethnic minority community. 	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 54 carers and no young carers. At the time of our inspection, the practice had 2916 patients registered at the practice. This equated to a percentage of 1.85%.
How the practice supported carers (including young carers).	A carers register was maintained by the practice, and patients were always asked at registration if they were a carer or if they had caring responsibilities. The practice also messaged the practice population asking them to inform the surgery if they were registered as a formal carer. The link for The Carers Support Services was included in the message and on the practice website to enable any carers to register as a formal carer. All carers were offered an annual health check.

How the practice supported recently bereaved patients.	Recently bereaved patients were contacted by their usual GP who provided additional support and information. Follow-up appointments were arranged if required.
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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.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Chaperoning information was available throughout the practice, including in waiting areas and consultation rooms, and trained staff were available to fulfil this role. 	

Responsive

Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The physical environment was accessible to patients who had limited mobility or used a wheelchair. Photographs of the clinical staff were provided on the doors to the clinic rooms to support people's interpersonal connection and communication as the wearing of face masks during the COVID-19 pandemic had posed challenges for some people. 	

Practice Opening Times	
Day	Time
Opening times: Main surgery	
Monday	9.30 am – 5 pm
Tuesday	9.30 am – 5 pm
Wednesday	9.30 am – 6.30 pm
Thursday	9.30 am – 5 pm
Friday	9.30 am – 5 pm
Appointments available: Main Surgery	
Monday	9 am-12 pm and 1pm- 3.30 pm
Tuesday	9 am-12 pm
Wednesday	9 am-12 pm and 1pm- 3.30 pm
Thursday	9 am-12 pm and 1pm- 3.30 pm
Friday	9 am-12 pm and 1pm- 3.30 pm
Opening times: Branch surgery	
Monday	8 am- 12.30 pm and 4 pm – 6.30 pm
Tuesday	8 am- 12.30 pm and 4 pm – 6.30 pm
Wednesday	8am - 12.30 pm.
Thursday	8 am- 12.30 pm and 4 pm – 6.30 pm
Friday	8 am- 12.30 pm and 4 pm – 6.30 pm

Appointments available: Branch Surgery	
Monday	8.30 am -11 am and 4 pm – 6.30 pm.
Tuesday	8.30 am -11 am
Wednesday	8.30 am -11 am
Thursday	8.30 am -11 am
Friday	8.30 am -11 am and 4 pm – 6.30 pm.
Extended access: Wednesday	6.30pm – 7.30pm

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

- 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.
- Although both the practice and branch surgery were open during core hours (i.e. 8am to 6.30pm) with the exception of a Monday and Friday at the branch the latest appoint offered was at 3.30pm. However, the Primary Care Network (PCN) extended access clinics were provided seven days a week; 6.30 pm to 8pm Monday to Friday and 8 am to 12 noon on Saturday and Sundays at Clee Medical Centre. Patients had access to routine appointments with a GP, Health Care Assistant or Practice Nurse.
- There was extended access on Wednesday evenings between 6.30 pm and 7.30 pm when patients had access to a telephone consultation with their regular GP.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- 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.

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • A triage system had been introduced during the pandemic. Patients could book appointments by telephone, online or by visiting the practice in person. Practice staff advised patients were allowed to request appointments with particular healthcare professionals, and this was always honoured when capacity and availability allowed. • The practice had maintained a good level of access for patients throughout the pandemic. New systems had been introduced such as online and telephone consultations to assist this. 90% of patients requesting appointments were seen the same day. 	

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	93.8%	N/A	67.6%	Significant Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	89.5%	71.6%	70.6%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	82.7%	67.0%	67.0%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	93.4%	86.0%	81.7%	Tending towards variation (positive)

Any additional evidence or comments

The practice was performing significantly above both the average for their clinical commissioning group (CCG) area and for all the practices in England in all the above indicators.

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

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

Explanation of any answers and additional evidence:

- The complaint policy and procedures were in line with national guidance.
- Concerns were taken seriously and lessons learnt to improve the quality of care.
- Patients had access to a suggestion box, practice questionnaire and the family and friends survey to provide feedback which were situated in the reception areas.

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The leadership team were committed to improving the quality of healthcare for their patients and the wider local community.• Staff felt supported by management at the practice and reported there was an open-door policy.	

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.	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: <p>The new partnership had taken over the service in July 2020, during a very challenging time due to the COVID-19 pandemic and the following recovery period, with increasing patient expectations and demands. They had a good understanding of the difficulties faced and were being proactive in addressing them.</p> <p>The practice's mission centred around 'providing patients with high quality personal care and to seek continuous improvement in the health status of the whole practice population'. To achieve this the practice was developing and maintaining a team-based approach which was responsive to patients' needs and expectations and reflected, when possible the latest advances in primary care. Staff were aware and understood practice's aims and had been involved in their development.</p>	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	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 had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff were positive about working for the practice and several members of staff had worked for the practice for significant periods of time. They felt very supported • Staff reported that they felt supported and able to raise concerns without fear of retribution. For example, the Practice Nurse explained they had been struggling with the workload in recent months and after discussing this issue with the GP partners, a health care assistant had been employed and automated BP monitoring introduced with positive results on workload demands and patient waiting times. 	

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

Source	Feedback
Staff questionnaires	<p>All staff were very positive about the service and the management team. Staff described the relationship between the staff team as 'exceptionally good' and how 'everybody feels comfortable with each other and work well as a team.'</p> <p>Staff were clear about their roles and responsibilities. They understood the mission statement and ethos at the practice was to provide the best care and service possible and 'aimed for this to happen every day.'</p>

Governance arrangements

Although there were clear roles and responsibilities, the practices governance and management systems did not always operate effectively.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	P (1)
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: (1) The practice had a governance framework structure, however the governance and management systems did not always operate effectively, as we identified several concerns during the inspection that had not been identified or resolved by the practice. These included storage and reconciliation of blank prescriptions; effective monitoring of fridge temperatures where vaccines were stored and shortfalls in the recruitment practices. The provider has assured us the majority of issues identified during this inspection have already been rectified post inspection. We will review progress made during a subsequent follow up inspection to ensure new procedures are being maintained.	

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	P (1)
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	P (2)
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: look at practice action plans. (1) There were areas relating to recruitment, prescription safety and vaccine safety which had not been effectively managed. (2) Arrangements for ensuring risks had been identified, managed and mitigated was not evidenced consistently. Although there were systems in place to manage risks and the management team confirmed the actions taken to mitigate risk/make improvements, there were shortfalls in the records and audit trail of actions taken. Areas included: new and legacy patient safety alerts and	

environmental risk assessments in relation to legionella, fire safety and health and safety. Following the inspection, we received documented evidence of newly implemented recording systems and completed action plans.

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had endeavoured to provide some face to face appointments when possible during the pandemic. Patient feedback was positive about access arrangements. Patients could access care and treatment remotely, where appropriate. This included facilities for patients to securely send in photographs and information or speak with clinicians virtually. The practice did not report any significant backlogs in care and treatment as a result of the pandemic and had plans to address any areas with minor backlogs such as spirometry appointments. 	

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.	Y
Performance information was used to hold staff and management to account.	Y

Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
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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.	Y
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
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The Patient Participation Group had held their first meeting since the pandemic in May 2022. • Concerns received by the practice were taken seriously and action taken to make improvements. • Feedback from patients informed service improvements. 'You said' - 'we did' feedback information was available in the reception areas. This detailed improvements had been made to the number of telephone consultations and appointments outside surgery hours, choice of surgery to attend and one-to-one advice on how to register for on-line services. 	

- Staff questionnaires were completed prior to the inspection. All staff reported a positive, open culture at the practice where they were encouraged to provide feedback and suggestions. Staff felt the leadership team were always approachable and they felt valued.

Feedback from Patient Participation Group.

Feedback

Patient Participation Meeting held on 11 May 2022: attendees very happy with service from the practice and would recommend to others. Suggestions were made to increase the number of face-to-face appointments and to provide more information about which doctor is attending the main/ branch surgery.

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: <ul style="list-style-type: none"> • There was good evidence of learning and improvement when things went wrong in relation to concerns raised and incident management. • The provider had introduced a contraception service and now carried out minor surgery procedures. The practice accepted referrals from other practices. 	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **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.