

# Care Quality Commission

## Inspection Evidence Table

### The Practice Lincoln Green (1-626549108)

Inspection date: 25 August 2022

Date of data download: 17 August 2022

## Overall rating: Good

### Safe

### Rating: Good

#### 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"><li>• There were comprehensive safeguarding adults and children policies, which were accessible to staff.</li><li>• There was a chaperone policy, which included details of training and appropriate checks required to undertake the role.</li><li>• There were local and organisational safeguarding leads for adults and children. Staff knew who to contact in the event of any safeguarding concerns.</li><li>• We saw minutes from a meeting where safeguarding concerns had been discussed. It was noted that there had not been regular meetings in place for a period of time. We were informed that staffing levels had impacted on attendance. However, the provider had put in place a regular meeting schedule and staff had been made aware.</li></ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The recruitment policy identified the necessary checks which were to be taken prior to the employment of new staff.</li> <li>• The provider had a human resources department and a comprehensive system in place which supported the recruitment process.</li> <li>• We reviewed a sample of personnel files for the most recently employed staff. We found they included the relevant information, such as evidence of qualifications, references, photographic identification, interview notes and disclosure and barring service checks.</li> <li>• The practice also regularly used locums and agency staff. We saw evidence demonstrating that all the correct checks had been undertaken.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 18/08/2022	Yes
There was a fire procedure. Date of fire risk assessment: 01/12/2021	Yes
Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• We saw that a health and safety audit had been conducted by an external organisation. Areas had been identified which required action, for example: <ul style="list-style-type: none"> <li>- Fire extinguishers blocked exits in reception – these had been rectified.</li> <li>- Missing signs off a fire extinguisher stand – these were awaiting completion by the manager of the premises.</li> <li>- Regular flushing of water outlets and records in place – processes had been put in place.</li> </ul> </li> <li>• There was a range of up to date risk assessments in place, such as the control of substances hazardous to health (COSHH), use of medical equipment, handling sharps and lone working.</li> <li>• A fire evacuation event had taken place on 10/05/2022 and we saw evidence that staff had attended this.</li> <li>• Weekly testing of the fire alarms took place and records were kept.</li> <li>• Electrical equipment and portable appliance testing were up to date.</li> </ul>	

## 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. Date of last infection prevention and control audit: June 2022	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:	
<ul style="list-style-type: none"> <li>• There was a comprehensive infection prevention and control (IPC) policy which was accessible to all staff. The policy stated the frequency of when IPC audits were to be undertaken, which also included checks of hand hygiene compliance.</li> <li>• There was a nominated IPC lead who had been appropriately training and completed IPC audits every six months.</li> <li>• We saw actions had been identified through the IPC audit, such as: <ul style="list-style-type: none"> <li>- Some waste bins were not foot operated – this action had been completed.</li> <li>- There was a lead under the sink in one of the rooms. We saw evidence that the practice had contacted the premises' landlord to report the issue on several occasions. However, they were still waiting for this issue to be rectified. The room was not being used for patient consulting at the time of our inspection.</li> <li>- Some maintenance and redecoration of the premises.</li> <li>- Identified issues regarding the cleaning of the premises, including clarification of the cleaning schedule. (The cleaning contract was with the landlord of the premises, to undertake cleaning duties in the building as a whole.)</li> </ul> </li> <li>• We saw evidence where the practice had raised their concerns with both the landlord of the premises (Leeds Community Healthcare Trust) and the local clinical commissioning group (now known as the West Yorkshire Integrated Care Board).</li> <li>• Post-inspection we also raised these issues with the integrated care board.</li> </ul>	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
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	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Non-clinical staff told us they worked flexibly to manage absences within the team. Systems were in place so that any unplanned sickness absences could be managed quickly.</li> <li>• Staff told us their workloads were manageable but felt the practice needed more permanent clinical staff.</li> <li>• The practice regularly used locums to deliver clinical sessions. On occasion patients' appointments had either needed to be changed or cancelled due to locums' non-attendance at the practice. (These instances had been recorded on the practice incident reporting system.) The practice was actively recruiting staff and had recently employed two salaried GPs.</li> <li>• We were informed of the current vacant advanced nurse/care practitioner (ANP) hours. The practice was using a self-employed contracted ANP. However, they were actively recruiting to this post. In the light of national recruitment issues, the practice was also in the process of reviewing their staffing requirements to support service delivery.</li> </ul>	

### 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. <sup>1</sup>	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"> <li>• At the time of our inspection, as a result of staffing shortages and turnover of patients, there was a backlog of the summarising of hard copy patient records. Action had been taken to ensure that any outstanding records did not relate to patients who were deemed to be at risk, vulnerable or had complex health needs.</li> <li>• Clinical records for new patients to be registered at the practice were mostly received by electronic transfer (via a GP to GP system), whilst waiting for paper records to be sent by Primary Care Support England (PCSE). This ensured that for the majority of patients, information was recorded in their electronic record.</li> <li>• New patients registering with the practice were required to complete a registration form, where they were asked to document any key information, such as allergies, prescribed medications and medical history.</li> </ul>	

- On the day of the inspection site visit, we saw that there were no outstanding referrals or results which required attention.

## Appropriate and safe use of medicines

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

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.60	0.82	0.79	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2021 to 31/03/2022) (NHSBSA)	7.2%	6.7%	8.8%	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 (01/10/2021 to 31/03/2022) (NHSBSA)	5.46	4.70	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	208.9‰	111.8‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.54	0.48	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	5.7‰	4.9‰	6.8‰	No statistical variation

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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes

Medicines management	Y/N/Partial
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 structured 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 high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England 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.	n/a
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	
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"> <li>• There were policies relating to cold chain and vaccine storage, which included guidance on what to do should the vaccine refrigerator temperatures fall out of range.</li> <li>• There was a suite of policies and protocols relating to medicines management, including prescription security and the monitoring of patients who were prescribed high-risk drugs.</li> <li>• We found that medicines, vaccines and prescription stationery were appropriately stored and monitored during our onsite visit.</li> <li>• The practice had risk assessed what emergency medicines they required.</li> <li>• Non-medical prescribers had access to clinical supervision and used a drug formulary to prescribe. They had access to a GP or the GP clinical lead, should they need further advice or clarification.</li> </ul>	

**Any additional evidence or comments**

As part of our inspection, we conducted a series of clinical searches of patient records to assess the practice's procedures around medicines management and prescribing. A remote electronic review of the searches was undertaken by the CQC GP specialist advisor (SpA) and were visible to the practice. The searches were carried out on the following:

- Patients who were prescribed methotrexate, which is a disease-modifying antirheumatic drug (DMARD). The search showed that there were six patients, all of whom had received appropriate monitoring in line with guidance.
- Patients who were prescribed azathioprine (a DMARD). The search showed that there was one patient and they had received monitoring in line with guidance.
- Patients who were prescribed a potassium-sparing diuretic (used to increase the amount of fluid passed from the body in urine, whilst also preventing too much potassium being lost with it). The search showed there were 25 patients, two of whom had not received the required monitoring. We saw that attempts had been made to contact those patients.

## Track record on safety and lessons learned and improvements made

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded 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"> <li>• There was an incident management policy, which informed staff how to report incidents.</li> <li>• Out of the nine incidents recorded, five of these related to locums either not attending the practice or cancelling. We discussed these and were informed that in the event of this occurring they would try to source another locum. On occasion they needed to make another appointment for the patient. They also contacted the local extended access service to request additional appointments as necessary.</li> </ul>	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• There was a policy for the management of safety alerts.</li> <li>• We saw that a log was kept of all alerts. This record identified the person responsible for dealing with them and what date actions had been completed.</li> <li>• As part of the inspection, we reviewed the management of Medicine and Healthcare products Regulatory Agency (MHRA) alerts. For example, an alert regarding mirabegron (used in the management of urinary frequency, urgency and incontinence in overactive bladder syndrome). Two patients had been identified by the search. They were both slightly overdue their blood pressure monitoring. The overall risk was low. The practice informed us they would contact these patients and complete the appropriate monitoring.</li> </ul>	



## 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 were delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>A clinical decision tool was integrated into the clinical system, which allowed easy access to the latest evidence-based guidance. Locally used templates were also embedded into the system. These supported safety, consistency and clinical effectiveness.</li></ul>	

### Effective care for the practice population

Findings
<ul style="list-style-type: none"><li>Clinicians worked with other health and care professionals to deliver coordinated packages of care.</li><li>The practice had access to midwifery and health visiting services to support families and children.</li><li>The district nursing teams provided some support for patients who were housebound.</li></ul>

- New patient checks and appropriate health assessments were available, including NHS health checks for patients aged 40 to 74 years. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Influenza, pneumonia and shingles vaccinations were available for patients who fitted the criteria.
- Patients with a learning disability were invited for an annual health check.
- There was a system in place to identify people who misused substances.
- Patients with poor mental health, including dementia, were assessed, monitored and referred to appropriate services.
- A clinical tool was used to identify older patients who were living with moderate or severe frailty. The patients received a full assessment of their physical, mental and social needs.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Gold Standard Framework meetings took place, where patients who were receiving palliative care were discussed to ensure their needs were being met.
- The practice had access to a primary care network patient ambassador to whom patients could be referred for additional support as needed.

## Management of people with long term conditions

### Findings

As part of our inspection, we conducted a series of remote clinical searches of patient records to assess the practice's procedures for the management of patients with long-term conditions. A review of the searches was undertaken by the CQC GP specialist advisor (SpA) without visiting the practice.

In general, our GP SpA found the management of patients with long-term conditions was good, particularly given the challenges of service provision during the pandemic and some patients not wishing to attend the surgery. The majority of patients we reviewed who had a long-term condition, such as asthma or diabetes, had been followed-up appropriately. Some patients had not attended their appointments and were being followed-up by the practice.

We were informed that:

- Patients with a long-term condition were offered a structured review, in line with the relevant guidance, to check their health and medicines needs were being met.
- Patients were seen and reviewed as befit their ongoing needs, for example if they were experiencing an exacerbation of their illness.
- The practice used specific electronic templates for recording long-term reviews and patient information.
- Adults with either newly diagnosed, or at risk of, cardiovascular disease were offered statins in line with local guidance.
- Patients with asthma and chronic obstructive pulmonary disease (COPD) were provided with management of care plans. Prescriptions for rescue medications were available for patients as necessary.
- Staff who were responsible for the care, treatment and reviews of patients with a long-term condition had received specific training.
- There was a process in place for following-up patients who did not attend their appointments.

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)	44	52	84.6%	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)	38	44	86.4%	Below 90% minimum
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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	38	44	86.4%	Below 90% minimum
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)	38	44	86.4%	Below 90% minimum
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)	58	71	81.7%	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"> <li>The practice was located in an area of high deprivation within Leeds, which included people from other countries and cultures. There is published evidence (accessed via NHS England) which correlates low uptake childhood immunisation rates with deprivation and certain ethnicities. We were informed of the difficulty in obtaining, and the recording of, information when children had received immunisations elsewhere, such as their country of origin.</li> <li>The practice had processes in place to manage childhood immunisations. There was a nominated individual who maintained a spreadsheet to monitor attendance. Anyone who did not attend was contacted and offered another appointment.</li> </ul>

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: 31/03/2022) (UK Health and Security Agency)	54.8%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	57.6%	64.0%	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)	50.2%	65.8%	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)	25.0%	52.2%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

#### Any additional evidence or comments

- The practice was located in an area of high deprivation with a multicultural community, which included patients from black and minority ethnic groups. There is a lower take-up of cervical screening from women of these groups. We were informed that there were barriers in some population groups who expressed reluctance to engage with the cervical screening programme. For example, cultural, lack of understanding, fear and embarrassment. Staff undertaking cervical screening procedures provided patients with advice and support regarding the importance and benefits of attending for screening.
- There was a policy in place for the management of cervical screening cytology results, to ensure all results were dealt with accordingly. Patients who did not attend were contacted and offered another appointment.
- Patients who worked were able to attend for cervical screening at the extended access hub in the evenings and at weekends.
- The provider had a quality improvement plan in place regarding cervical cancer screening. They had identified the highest uptake rate was within the 50 to 65-year age range. The practice was currently looking at ways they could improve uptake rates, particularly in the younger age groups, which included providing education and dispelling any myths surrounding cervical screening.
- The local integrated care board also informed us of the work they were doing to support practices who experienced low uptake rates.

#### 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
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

Any additional evidence or comments
<p>The practice participated in a programme of two-cycle audits. We saw that they acted on any areas identified for improvement. For example:</p> <ul style="list-style-type: none"> <li>An audit of patients prescribed methotrexate (a disease-modifying medicine indicated in the treatment of severe, active, classical or definite rheumatoid arthritis, including juvenile arthritis, and severe psoriasis which is unresponsive to conventional therapy). The aims of the audit were to promote patient safety when prescribing the medicine as well as assess patient compliance. The first cycle had been carried out in April 2022. Seven patients had been identified, two of which were overdue their monitoring. The audit was repeated in July 2022, which identified one patient who was overdue but had an appointment booked. At each cycle, the practice raised awareness with clinicians and reaffirmed that medications on repeat prescriptions were only authorised until they were next due for monitoring.</li> </ul>

**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.	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:

- Information was maintained regarding the professional registrations of staff to ensure they were up to date and appropriately registered.
- We saw that staff received mandatory training and other training relevant to their roles. A training matrix was maintained to ensure that all staff were up to date.
- There was a clinical supervision policy in place. At the time of our inspection, the practice nurse accessed clinical supervision inhouse and supported the healthcare assistants. The self-employed advanced nurse practitioner received external clinical supervision as required.
- We discussed how they managed clinical oversight of their locum staff. We were informed they were undertaking an audit on samples of clinical records and would be discussing outcomes with individuals as appropriate.
- Nursing records were audited on a rolling three-month basis.
- We discussed the support and supervision regarding the newly recruited GPs. We were informed there was a system in place for them and they had access to the GP clinical lead.

## Coordinating care and treatment

### Staff worked 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.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice had recommenced clinical meetings. which were minuted. Patients were discussed to ensure their care and treatment needs were being met appropriately. These meetings had not previously been taking place regularly due to staffing levels.</li> <li>• The practice worked collaboratively with the local primary care network (PCN) to deliver services as befitted the needs of their patients.</li> </ul>	

## 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
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### Consent to care and treatment

#### The practice was able to demonstrate that it 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice had recently audited patients with a DNACPR and Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) in place. They found there were nine patients with these in place, all of which were appropriate.</li> <li>As part of our clinical searches, we reviewed five patients who had a DNACPR/ReSPECT in place. These were all documented appropriately.</li> </ul>	

## Caring

## Rating: Good

### Kindness, respect and compassion

#### Staff treated patients with kindness, respect and compassion.

	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: <ul style="list-style-type: none"> <li>On the day of the inspection site visit, we saw that staff spoke to patients in a respectful and helpful manner.</li> </ul>	

## National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

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 (01/01/2022 to 30/04/2022)	75.0%	86.2%	84.7%	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 (01/01/2022 to 30/04/2022)	74.9%	85.2%	83.5%	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 (01/01/2022 to 30/04/2022)	85.3%	93.7%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	66.1%	74.1%	72.4%	No statistical variation

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

## 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:	



- The practice website had links to other avenues of support and self-help, including a range of self-care fact sheets and a link to the NHS symptom checker.

### National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

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 (01/01/2022 to 30/04/2022)	78.6%	90.0%	89.9%	Tending towards variation (negative)

### Any additional evidence or comments

The practice had reviewed the national patient GP survey results. As a result of the satisfaction rates, they had raised increased awareness with clinicians to ensure that all care planning options were offered, along with full and clear explanations. Evaluation was to be undertaken through clinical meetings and supervision sessions.

	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"> <li>There was information for patients who may require interpretation or translation services, both in the practice and on the website.</li> </ul>	

Carers	Narrative
Percentage and number of carers identified.	51 (1% of patient population) carers had been identified.
How the practice supported carers (including young carers).	When patients registered with the practice, as part of the new patient check they were asked if they were a carer.

	Carers were encouraged to register with the local carers' support schemes and groups. Carers were invited for relevant vaccinations, such as those for protection against influenza and COVID related viruses.
How the practice supported recently bereaved patients.	Bereavement cards were sent to registered patients and a follow-up telephone call as appropriate. Individual support was offered, as needed, to patients who experienced bereavement.

## 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

## Responsive

## Rating: Good

At the last inspection we rated the practice as outstanding for providing responsive services because:

- Educational workshops were provided for patients who had a diagnosis of diabetes to improve their understanding and self-management. The practice also delivered educational sessions in a local primary school and supermarket.
- One of the practice nurses had co-founded the Leeds Respiratory Network Group.
- Mindfulness and guided meditation sessions were provided for patients.
- There was a proactive approach to the education of patients and they could evidence a reduction in accident and emergency attendances as a result.

At this inspection, we found that some of those areas previously regarded as outstanding practice were no longer in operation, as a result of staff leaving the practice and shortfalls in staffing overall. At this inspection, the threshold for achieving an outstanding rating had not been reached. The practice is therefore now rated good for providing responsive services

## 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.	Partial
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:	
<p>The premises were leased and shared with other community services, including another GP practice and a walk-in centre. There was no space for further development by the practice, such as having additional consulting rooms to accommodate patient demand. The premises required updating and maintenance in the majority of areas. We saw there was a leak in one of the rooms and some ceiling tiles needed replacing. (This room was not being used for patient consultations due to the leak.) The practice had contacted the landlord on several occasions to inform them of the repairs which needed to be undertaken. Post-inspection, we spoke with the local integrated care board to raise the issues regarding the premises, maintenance issues and availability of space.</p>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 8pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> <li>• Appointments were available throughout the day.</li> <li>• The practice was aware of the challenges faced by their population in a deprived area and the impact on health and wellbeing. In recognition of some of the complex cases seen the practice provided longer appointments so that patients had time to discuss their needs.</li> <li>• Patients had access to extended hours appointments at evenings and weekends at hubs based in Leeds, which were organised by the local confederation.</li> <li>• The practice was based in the same premises as a walk-in centre which operated 8am to 8pm, 365 days a year, where patients had access to services.</li> <li>• Out of hours cover was provided by Local Care Direct. Patients were directed to contact NHS 111 when the practice was closed.</li> <li>• 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.</li> <li>• The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.</li> <li>• The practice liaised with the district nursing team to support those patients who were housebound.</li> </ul>

## 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 minimise the length of time people waited for care, treatment or advice	Yes
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	Yes
There were systems in place to support patients who face communication barriers to access treatment	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"> <li>During the inspection site visit we saw that there was availability of appointments throughout the day, should patients wish to be seen.</li> </ul>	

## National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

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 (01/01/2022 to 30/04/2022)	50.7%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	61.6%	57.9%	56.2%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	63.2%	56.1%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	70.5%	73.6%	71.9%	No statistical variation

### Any additional evidence or comments

The provider reviewed the national GP patient survey and had developed an action plan to address areas where patient satisfaction rates were low.

With regards to access and appointments, they were in the process of implementing a new telephone system. The system would support the practice in monitoring call volume and answer rates. In times of high volume, they would then have the ability to request assistance from the provider's regional team.

They had reviewed the current appointment system and increased the number of pre-bookable, online and urgent on the day appointments.

They were also participating in a recruitment drive and had recruited two salaried GPs, who were commencing employment later in the year.

### 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.	3
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>There was information regarding how to make a complaint both in the practice and on their website.</li> </ul>	

- In the event a complainant was not satisfied with the outcome of a complaint, they were appropriately directed to the Parliamentary and Health Service Ombudsman (PHSO).
- Two out of three of the complaints related to prescriptions. We saw that, as a result, the practice had raised awareness with staff to ensure that they deal with requests for prescriptions in a safe and timely way.

## Well-led

**Rating: Good**

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence:	
The provider described the challenges they faced, particularly regarding recruitment of staff at the practice, and the steps they were taking to address them. At the time of our inspection, a recruitment campaign was underway and they had already recruited two additional GPs.	

### Vision and strategy

**The practice had a clear vision and 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"> <li>• The practice's statement of purpose was made available on their website.</li> <li>• They displayed their ethos as being based on four fundamental principles:               <ol style="list-style-type: none"> <li>1. To provide the highest quality of care to all our patients regardless of their background.</li> </ol> </li> </ul>	

2. To treat every patient holistically- this means looking at social, psychological and physical reasons when trying to deal with their problems.
3. To continuously strive to improve the quality of care we provide as a team by being a “learning organisation”. This means learning from both good and bad aspects of our practice and to identify learning needs based upon this.
4. To be involved in the teaching and training of other health professionals such as medical students, Doctors, Nurses, Counsellors and physiotherapists.

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes

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

Source	Feedback
Staff interviews and questionnaires	<p>We spoke with several members of staff during the inspection and received completed staff questionnaires. Staff informed us that:</p> <ul style="list-style-type: none"> <li>• They felt supported both locally and organisationally.</li> <li>• The manager and GPs were approachable and supportive.</li> <li>• They had access to the equipment and training necessary to enable them to perform their roles well.</li> <li>• They enjoyed working at the practice, worked well as a team and were supportive of one another.</li> <li>• They spoke negatively of the premises and that they felt it needed to be updated and modernised.</li> </ul>

## Governance arrangements

### There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The provider had a corporate structure, which included an executive team, a clinical and operational board and an integrated governance committee. The practice team reported to a regional board who met weekly and escalated any communications to the clinical and operational board. The integrated governance committee provided oversight of governance procedures at practice level.</li> <li>Staff were aware of who the leads were within the practice and at regional level.</li> <li>All policies had been developed by the provider and made available to staff at the practice.</li> </ul>	

### Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes

#### 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.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes



The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>All backlog of activity which had been caused by the pandemic had been addressed. However, there were still some outstanding patient records which required summarising. We were informed the practice was taking steps to address this.</li> <li>Although the practice had recruitment issues, we saw that there was a GP on duty each day and that, on the day of the site visit, there were some appointments available.</li> </ul>	

### 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.	Yes

### 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

### Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active patient participation group.	No
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The practice had developed an action plan regarding reinstating a patient participation group (PPG). They had recently recruited five participants.</li> <li>• There was information available on the practice's website, informing patients of what a PPG was and how to join; should they wish to do so.</li> <li>• The provider and practice staff had met recently with members of the local integrated care board (formerly Leeds clinical commissioning group). This meeting was to review contractual and quality related issues, and provide support as needed</li> <li>• Practice and clinical meetings had recently recommenced on a monthly basis. These were minuted and were accessible for staff to read. Staff had the opportunity to raise any concerns or ideas at those meetings.</li> <li>• The practice used feedback from patients, including complaints, to improve services.</li> <li>• The practice had undertaken a staff survey in November 2021 and used information to drive improvements.</li> </ul>	

### Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The practice engaged with their commissioners and neighbouring practices in local current and future initiatives, which included members of the primary care network (PCN).</li> </ul>	

- The clinical searches undertaken as part of the inspection found effective systems and processes for monitoring the care and treatment of patients.

#### Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. 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.