

Care Quality Commission

Inspection Evidence Table

Brompton Medical Centre (1-4719674064)

Inspection date: 29 June 2021

Date of data download: 07 June 2021

Overall rating: Requires Improvement

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

We rated the practice as Requires Improvement overall because:

- The practice's computer system did not alert staff of all family and other household members of children that were on the risk register or adults that were on the vulnerable adult register.
- Published results showed that the practice's prescribing indicators were all now in line with local Clinical Commissioning Group (CCG) and England averages. However, on the day of our inspection we found that Patient Group Directions (PGDs) had not been completed correctly and improvements were required to the management of high-risk medicines prescribing.
- Patients' needs were assessed, but care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance.
- The pandemic had had a detrimental effect on the practice's ability to deliver some care as well as treatment. However, improvements were required for some types of patient reviews as well as subsequent follow up activities.
- Published performance results for diabetes indicators had improved and were now in line with or above local and national averages.
- Staff were consistent and proactive in helping patients to live healthier lives. However, improvements in the recording of the care and treatment of patients receiving palliative care were required.
- The practice obtained consent to care and treatment in line with legislation and guidance. However, improvements in the recording of patients' resuscitation statuses were required.
- There was compassionate and inclusive leadership at all levels.
- There were processes and systems to support good governance and management.
- The practice's processes for managing risks, issues and performance were not always effective.
- Backlogs in relation to cancer screening were in the process of being addressed by the practice.
- The practice engaged with the public, staff and external partners and was in the process of reinstating a patient participation group.

Safe

Rating: Requires Improvement

We rated the practice as Requires Improvement for providing safe services because:

- The practice's computer system did not alert staff of all family and other household members of children that were on the risk register or adults that were on the vulnerable adult register.
- Appropriate standards of cleanliness and hygiene were met.
- Staff had the information they needed to deliver safe care and treatment.
- Published results showed that the practice's prescribing indicators were all now in line with local Clinical Commissioning Group (CCG) and England averages. However, on the day of our inspection we found that Patient Group Directions (PGDs) had not been completed correctly and improvements were required to the management of high-risk medicines prescribing.
- There were effective systems for recording and acting on significant events as well as managing safety alerts.

Safe systems and processes

The practice's systems, practices and processes did not always keep people safe and safeguarded from abuse.

Safeguarding	
There was a lead member of staff for safeguarding processes and procedures.	Yes
Policies and other documents covering adult and child safeguarding were accessible to all staff. They clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare.	Yes
GPs and staff were trained to appropriate levels for their role and knew how to identify and report concerns.	Yes
The practice worked in partnership with other agencies to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. Information about patients at risk was shared with other agencies in a timely manner.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
Notices in the practice advised patients that chaperones were available if required.	Yes

Additional evidence or comments

During our inspection in April 2019 we found that the practice's computer system alerted staff of children that were on the risk register. However, it did not alert staff of all family and other household members of children that were on the risk register.

At our inspection in June 2021 we found that the practice's computer system alerted staff of children

that were on the risk register as well as adults on the vulnerable adult register. However, it did not alert staff of all family and other household members of children that were on the risk register or vulnerable adults on the vulnerable adult register.

Recruitment systems	
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Additional evidence or comments	
<p>During our inspection in April 2019 we found that one member of clinical staff required a hepatitis b vaccination booster as their hepatitis b antibody level was indeterminate. Records showed that this was detected by a blood test on 18 April 2019. Staff told us that this member of staff had been on leave since the result was received, and they were due to receive the hepatitis b vaccination booster on their return (7 May 2019).</p> <p>At our inspection in June 2021 we found that the member of staff who required a hepatitis b vaccination booster was no longer working at the practice. We looked at the records of two other clinical staff and saw that their hepatitis b vaccination status was up to date.</p>	

Safety systems and records	
There were up to date fire risk assessments that incorporated an action plan to address issues identified.	Yes
The practice had a fire evacuation plan.	Yes
Records showed fire extinguishers were maintained in working order.	Yes
Records showed that the practice carried out fire drills.	Yes
Records showed that the fire alarm system was tested regularly.	Yes
The practice had designated fire marshals.	Yes
Staff were up to date with fire safety training.	Yes
All electrical equipment was checked to help ensure it was safe to use.	Yes
All clinical equipment was checked and where necessary calibrated to help ensure it was working properly.	Yes

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

We observed the premises to be clean and all areas accessible to patients were tidy.	Yes
There was a lead member of staff for infection prevention and control who liaised with the local infection prevention teams to keep up to date with best practice.	Yes

There was an up to date infection prevention and control policy.	Yes
There was an up to date infection prevention and control audit that incorporated an action plan to address issues identified.	Yes
Relevant staff were up to date with infection prevention and control training.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Additional evidence or comments	
<p>During our inspection on 29 June 2021 we saw that all relevant staff were wearing personal protective equipment (PPE) correctly and adhering to current best practice guidance on COVID-19. For example, wearing face coverings and keeping a distance of at least one meter from others.</p> <p>Hand sanitising gel was available throughout the practice for patients, staff and visitors to use.</p>	

Risks to patients, staff and visitors

Risks to patients, staff and visitors were assessed, monitored or managed. However, the practice did not have all the emergency equipment that was required to be kept for use in an emergency on the day of our visit.

The provider had systems to monitor and review staffing levels and skill mix.	Yes
There was an effective approach to managing staff absences and busy periods.	Yes
Staff knew how to respond to emergency situations.	Yes
All staff were up to date with basic life support training.	Yes
Emergency equipment and emergency medicines were available in the practice including medical oxygen and an automated external defibrillator (AED).	Partial
Records showed that emergency equipment and emergency medicines were checked regularly.	Partial
Emergency equipment and emergency medicines that we checked were within their expiry dates.	Yes
There was up to date written guidance for staff to follow in the event of major incidents that contained emergency contact telephone numbers.	Yes
There was written guidance for staff to follow to help them identify and manage deteriorating or acutely unwell patients.	Yes
Staff were up to date with training in how to identify and manage patients with severe infections. For example, sepsis.	Yes
There were a variety of health and safety risk assessments that incorporated action plans to address issues identified.	Yes
There was an up to date health and safety policy available with a poster in the practice which identified local health and safety representatives.	Yes

There was an up to date legionella risk assessment and an action plan to address issues identified.	Yes
Additional evidence or comments	
<p>The practice did not have all the emergency equipment that was required to be kept for use in an emergency. We looked but could not find a paediatric pulse oximeter.</p> <p>The inventory of emergency equipment used by staff when carrying out regular checking did not include an adult pulse oximeter or a paediatric pulse oximeter.</p> <p>After our inspection the provider wrote to us with evidence to show that a paediatric pulse oximeter was now available in the practice and that the inventory of emergency equipment had been updated to include an adult and paediatric pulse oximeter.</p>	

Information to deliver safe care and treatment

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

Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented.	Yes
The practice had a documented approach to the management of test results, and this was managed in a timely manner.	Yes
The practice demonstrated that when patients used multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes

Appropriate and safe use of medicines

The arrangements for managing medicines did not always keep patients safe.

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) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.67	0.74	0.70	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). (01/04/2020 to 31/03/2021) (NHSBSA)	9.9%	10.8%	10.2%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
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 (01/10/2020 to 31/03/2021) (NHSBSA)	5.70	5.89	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	121.1‰	131.9‰	126.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	0.95	0.69	0.66	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	6.5‰	6.5‰	6.7‰	No statistical variation

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

Medicines management	
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescription forms and pads were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	No
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.	No
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	Yes
Up to date local prescribing guidelines were in use.	Yes

Additional evidence or comments
At our inspection in June 2021 we looked at 12 Patient Group Directions (PGDs). None of the PGDs we looked at had been completed correctly. All 12 PGDs did not have blank areas crossed through after signing by a GP and additional staff had been added to the blank areas after the date the PGDs had originally been signed by the GP.

After our inspection the provider wrote to us with evidence to show that they had revised the PGDs used at Brompton Medical Centre and that all PGDs had now been completed correctly.

At our inspection in June 2021 we looked at the records of eight patients who were prescribed warfarin. We found that one of these patients' records showed their last blood test was 12 March 2020 and their last prescription for warfarin was 1 April 2021. We also found that another one of these patients' records showed that their last blood test was 8 February 2021 and their last prescription for warfarin was 19 March 2021. This was not in line with best practice guidance for the management of this high-risk medicine.

After our inspection the provider wrote to us with further evidence of their monitoring of patients who were prescribed warfarin. This evidence showed that for some patients, who were overdue relevant blood testing, there was an action plan to prevent further prescribing of this high-risk medicine without the patient attending for relevant blood testing.

At our inspection in June 2021 we looked at the records of five patients who were prescribed methotrexate. We found that all these patients' records showed that best practice guidance for the management of this high-risk medicine had been followed.

At our inspection in June 2021 we looked at the records of two patients who were prescribed lithium. We found that the practice's computer system alerted staff to one of these patients but not the other. Records showed that the patient where the practice's computer system did not alert staff that they were prescribed lithium, had not been prescribed lithium since 30 March 2021. We looked but could not find records to demonstrate why no further prescriptions of lithium had been issued to this patient nor that any follow up action had been taken by the practice to establish the reason for the lack of further prescriptions of this high-risk medicine for this patient.

After our inspection the provider wrote to us and told us that three patients who were prescribed lithium and had not been reviewed within the last 12 months had now received a review.

During our inspection in April 2019 we established that the practice was aware that their prescribing of some antibiotics and some analgesics were higher than local and national averages. An action plan had been developed and was in the process of being implemented to help reduce the prescribing of these medicines where possible. For example, the pharmacy technician employed by Sydenham House Medical Group was in the process of reviewing all Brompton Medical Centre's patients who were prescribed non-steroidal anti-inflammatory drugs (NSAIDs).

At our inspection in June 2021, published results showed that the practice's prescribing indicators were all now in line with local Clinical Commissioning Group (CCG) and England averages.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
There was a system for recording and acting on significant events.	Yes
There was up to date written guidance available for staff to follow to help them identify, report and manage any significant events.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses both internally and externally.	Yes
Number of events recorded in last 12 months:	1

Records showed that the practice had carried out a thorough analysis of reported significant events.	Yes
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There was evidence of learning and dissemination of information from significant events.	Yes
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Additional evidence or comments	
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Records showed that there had been one significant event in the last 12 months. Details of the event, which was a flood of the practice, had been reported by staff completing the relevant form. The event was investigated, and necessary action taken. No additional training was required as a result of this event.	
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Safety alerts	Y/N/Partial
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The practice had systems for managing safety alerts.	Yes
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Information from safety alerts was shared with staff.	Yes
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Staff understood how to deal with safety alerts.	Yes
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The practice acted on and learned from safety alerts.	Yes
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The practice kept records of action taken (or if no action was necessary) in response to receipt of all safety alerts.	Yes
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Effective

Rating: Requires Improvement

We rated the practice as Requires Improvement for providing effective services because:

- Patients' needs were assessed, but care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance.
- The pandemic had had a detrimental effect on the practice's ability to deliver some care as well as treatment. However, improvements were required for some types of patient reviews as well as subsequent follow up activities.
- Published performance results for diabetes indicators had improved and were now in line with or above local and national averages.
- Staff had the skills, knowledge and experience to carry out their roles.
- Staff worked together and with other organisations to deliver effective care and treatment.
- Staff were consistent and proactive in helping patients to live healthier lives. However, improvements in the recording of the care and treatment of patients receiving palliative care were required.
- The practice obtained consent to care and treatment in line with legislation and guidance. However, improvements in the recording of patients' resuscitation statuses were required.

Effective needs assessment, care and treatment

Patients' needs were assessed, but care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance.

The practice had systems and processes to help keep clinicians up to date with current evidence-based practice.	Yes
Staff had access to guidance from NICE and used this information to deliver care and treatment that met patients' needs.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Partial
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
Additional evidence or comments	
Patients with long-term conditions, such as asthma, hypertension and atrial fibrillation, and patients	

experiencing poor mental health (including dementia) were receiving relevant reviews. However, records showed that reviews did not always include all elements necessary in line with current best practice guidance. For example, an atrial fibrillation risk score, a record of blood pressure or Body Mass Index (BMI) or smoking status. We also looked but could not find evidence to show that all patient reviews that we looked at were followed up where necessary in a timely manner.

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. However, the pandemic had had a detrimental effect on the practice's ability to deliver some care as well as treatment, but improvements were required for some types of patient reviews as well as subsequent follow up activities.

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	528.4	533.9
Overall QOF score (as a percentage of maximum)	94.5%	95.5%
Overall QOF PCA reporting (all domains)	8.1%	5.9%

Older people

Population group rating: Good

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.

The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

The practice carried out structured annual medicines reviews for older patients.

Staff had appropriate knowledge of treating older people including their psychological, mental and communication 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.

People with long-term conditions

Population group rating: Requires Improvement

Findings

At our inspection in June 2021 we looked at the records of eight patients diagnosed with asthma. Records showed that all eight patients had received an asthma review. However, for one of these

patients, who reported coughing a lot each morning, we looked but could not find evidence to demonstrate that any action had been taken or follow up given since their asthma review on 7 May 2021. For another of these patients, whose asthma control test result was under target, we looked but could not find evidence to show that the task sent to a GP as a result of the under target asthma control test had been actioned or followed up since their asthma review on 19 May 2021.

GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.

At our inspection in June 2021 we looked at the records of eight patients who were diagnosed with chronic obstructive pulmonary disease (COPD). Records showed that all eight patients had received a COPD review carried out by nursing staff. No treatment changes were made as a result of any of these reviews. We looked but could not find evidence of the rationale being used by nursing staff when deciding if treatment changes were necessary or not.

At our inspection in April 2019 published performance results for hypertension indicators were below local and national averages. The practice was aware of these results and had taken action to make improvements. However, at our inspection in June 2021 published performance results for hypertension indicators remained below local and national averages.

At our inspection in June 2021 we looked at the records of eight patients who were diagnosed with hypertension. Records showed that all eight patients had received a hypertension review. However, for one of these patients, whose blood pressure was recorded as high on 11 February 2021 and who was prescribed medicine to help reduce their blood pressure, we looked but could not find evidence to show that they had been followed up since their review. For another of these patients, whose blood pressure was recorded as high on 24 November 2020, records showed that a GP had carried out a medicine review on 9 June 2021 and asked the patient to monitor and record their blood pressure at home. However, we looked but could not find evidence to show that they had been followed up since their review. Records also showed that for another of these patients their blood pressure had been recorded as high during a review on 26 February 2021. We looked but could not find evidence to show that they had been followed up since their review.

After our inspection the provider wrote to us and told us that they were taking action to improve the care and treatment of patients diagnosed with hypertension. For example, there were plans to hold weekly blood pressure clinics to review patients diagnosed with hypertension who were overdue a review.

At our inspection in June 2021 we looked at the records of eight patients who were diagnosed with atrial fibrillation (AF). Records showed that all eight had received an AF review. However, for one of these patients we looked but could not find evidence to show that an AF risk score (a CHADSVasc score) had been recorded in their records since 2016. This patient's records also showed that they were prescribed aspirin which was no longer indicated for the treatment of AF. Records of another of these patients showed that they were prescribed the correct anticoagulation medicine for the treatment of AF. However, we looked but could not find evidence that up to date relevant blood tests had been carried out.

After our inspection the provider wrote to us and told us that a review of patients on the practice's AF register had now been carried out by a GP. One patient was found not to have AF and was removed from their AF register. The GP stopped the prescription of aspirin for the patient who we found was being prescribed this medicine and another patient was currently receiving care and treatment for their AF directly from a cardiologist at a hospital.

Adults with newly diagnosed cardio-vascular disease were offered statins.

At our inspection in April 2019 published performance results for diabetes indicators was below local and national averages. The practice was aware of where these results were below local as well as national averages and had taken action to make improvements. At our inspection in June 2021 published performance results for diabetes indicators had improved and were now in line with or above local and national averages.

At our inspection in June 2021 we looked at the records of five patients who were diagnosed with diabetes. Records showed that all five had received a diabetes review in line with current best practice guidance.

Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.

Staff who were responsible for reviews of patients with long-term conditions had received specific training.

The practice could demonstrate how they identified patients with commonly undiagnosed conditions. For example, diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	75.9%	73.1%	76.6%	No statistical variation
PCA* rate (number of PCAs).	5.0% (7)	18.3%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	90.0%	87.3%	89.4%	No statistical variation
PCA rate (number of PCAs).	18.9% (7)	15.2%	12.7%	N/A
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	86.8%	79.5%	82.0%	No statistical variation
PCA rate (number of PCAs).	5.0% (2)	6.0%	5.2%	N/A

The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	84.1%	65.6%	66.9%	Variation (positive)
PCA rate (number of PCAs).	29.3% (34)	15.7%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	56.5%	69.8%	72.4%	Variation (negative)
PCA rate (number of PCAs).	6.9% (16)	8.2%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	87.5%	89.6%	91.8%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	4.1%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	80.2%	73.1%	75.9%	No statistical variation
PCA rate (number of PCAs).	21.6% (25)	12.4%	10.4%	N/A

Families, children and young people

Population group rating: Requires Improvement

Findings

Childhood immunisations were carried out in line with the national childhood vaccination programme. At our inspection in April 2019 NHS England published results showed that uptake rates were lower than the target percentage of 90% or above in three out of the four indicators. The provider was aware of these results and was taking action to make improvements. For example, when children were newly registered at the practice, staff asked to see the children's red book in order to check that they were up to date with childhood immunisations. The practice also ran searches of the computerised records system to ensure that all children registered were up to date with childhood immunisations. Staff told us that the practice's computer system also alerted staff to children that were not up to date with childhood immunisations. They were in the process of continuing to implement these improvement activities and were monitoring their efficacy.

At our inspection in June 2021 we saw that the number of children of an age where immunisations were indicated had increased by approximately one third. NHS England published results showed that uptake rates were lower than the target percentage of 90% or above in all five of the indicators. The provider was aware of these results and was taking action to make improvements. For example, searches of the practice's computerised records were now being carried out monthly to help identify children registered that were not up to date with their immunisations. Staff told us that the parents or guardians of children who were not up to date with immunisations were contacted by telephone, letter and SMS text message

offering appointments for immunisation. However, despite the appointments being accepted there was a high rate of patients who then failed to attend.

After our inspection the provider wrote to us and told us that a search of their computer system had now been carried out and that this had established that during the period 1 April 2019 to 31 March 2020:

- There were 74 children aged two years registered at the practice who were eligible for one dose of the Measles, Mumps and Rubella (MMR) vaccination.
- Of these, 61 (82.4%) had received one dose of the MMR vaccination.
- Records showed that 10 of these children had left the practice before being due the vaccination and one mother had declined the vaccination for her child.
- There were 83 children aged five years registered at the practice who were eligible for the second dose of the MMR vaccination.
- Of these, 36 (43.3%) had received the second dose of the MMR vaccination.
- Records showed that 47 children were on the excluded list and of these, 41 had left the practice before being due the vaccination and two mothers had declined the vaccination for their children.

The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.

Young people could access services for sexual health and contraception.

Staff had the appropriate skills and training to carry out reviews for this population group.

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) (01/04/2019 to 31/03/2020) (NHS England)	43	49	87.8%	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) (01/04/2019 to 31/03/2020) (NHS England)	39	44	88.6%	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) (01/04/2019 to 31/03/2020) (NHS England)	39	44	88.6%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	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) (01/04/2019 to 31/03/2020) (NHS England)	28	32	87.5%	Below 90% minimum
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Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

At our inspection in April 2019 published results showed that the practice's uptake for cervical screening was below the 80% coverage target for the national screening programme. Unverified data showed that the practice achievement rate for eligible patients who had attended for cervical screening had increased by 17% to 87%.

At our inspection in June 2021 published results showed that the practice's uptake for cervical screening as at December 2020 was below the 80% coverage target for the national screening programme. The provider was aware of these results. Staff told us that during the pandemic only patients at high risk of developing cervical cancer were called in for screening. The practice was in the process of taking action to make improvements. For example, all eligible patients were now being offered cervical screening appointments. Staff told us that these patients were contacted by telephone, letter and SMS text message offering appointments for cervical smear testing. However, despite the appointments being accepted there was a high rate of patients who then failed to attend.

After our inspection the provider wrote to us with evidence showing that as at 31 March 2020 the practice had achieved 8.34 points out of a possible 11 points for cervical screening. This represented an achievement of 75.8%.

At our inspection in April 2019 the practice's uptake for breast and bowel cancer screening was lower than local and national averages. Staff told us that patients who failed to attend for routine cancer screening were sent letters to remind them of their importance and encourage attendance.

At our inspection in June 2021 published results showed that the practice's uptake for breast and bowel cancer screening as at March 2020 was lower than local and national averages. The provider was aware of these results. Staff told us that during the pandemic, breast and bowel screening was paused by Public Health England. Now that screening had resumed the practice was in the process of taking action to make improvements. For example, all eligible patients were given an information leaflet encouraging screening uptake when they attended COVID vaccination clinics operated by the provider. Staff also told us that these patients were contacted by letter and SMS text message encouraging uptake of screening.

At our inspection in April 2019 we found that the number of new cancer cases treated which resulted from a two week wait referral was significantly lower than local and national averages. Staff told us that this was due to errors when staff applied read codes to patients' computerised records. Weekly monitoring had been introduced to help ensure these errors did not continue.

We looked at the records of six patients that had been diagnosed with cancer. The records showed that four of these patients, who presented with symptoms that indicated they should be referred under the two week wait system, had been referred correctly. However, records showed that the remaining

two patients, who also presented with symptoms that indicated they should be referred under the two week wait system, had not been referred appropriately. Of the two patients, one had been referred routinely in April 2017 and the other urgently in October 2017. Neither of these patients had been referred correctly to other providers under the two week wait referral system. This resulted in delays in them receiving further tests, investigations and treatments.

Staff told us that since January 2018 a system had been introduced to help identify and reduce incorrect referrals of patients who presented with symptoms that indicated they should be referred under the two week wait system. Patients who were diagnosed with cancer were now being routinely discussed at multidisciplinary clinical meetings. After our inspection the provider sent us evidence to demonstrate that one of the patients that had not been correctly referred under the two week wait system had been discussed at these meetings. The provider implemented additional changes to ensure that clinicians were obliged to attend these meetings, which enabled learning to take place.

At our inspection in June 2021 the number of new cancer cases treated which resulted from a two week wait referral was lower than local and national averages. Staff told us that they could not understand why published results were lower than local and national averages as the weekly monitoring that had been introduced was ensuring that errors when staff applied read codes to patients' computerised records were no longer taking place.

At our inspection we looked at the records of four patients that had been diagnosed with cancer. The records showed that all of these patients, who presented with symptoms that indicated they should be referred under the two-week wait system, had been referred correctly.

The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/12/2020) (Public Health England)	62.9%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	63.8%	70.6%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	53.0%	64.3%	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)	75.0%	89.7%	92.7%	N/A

Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	0.0%	55.4%	54.2%	Variation (negative)
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People whose circumstances make them vulnerable

Population group rating: **Good**

Findings

The practice held registers of patients living in vulnerable circumstances including homeless people and those with a learning disability to help ensure they received the care they needed.

The practice regularly worked with other health care professionals in the case management of vulnerable patients.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

All patients with a learning disability were offered an annual health check.

The practice reviewed young patients at local residential homes.

People experiencing poor mental health (including people with dementia)

Population group rating: **Requires Improvement**

Findings

At our inspection in June 2021 we looked at the records of eight patients that had been diagnosed with poor mental health. Records showed that all eight had received a mental health review. However, for one of these patients' records showed that their last review had been carried out on 2 March 2020. We looked but could not find evidence to show that a further review had been carried out after this date. For another one of these patients' records showed that their last review had been carried out on 29 April 2020. We looked but could not find evidence to show that a further review had been carried out after this date. Records also showed that for six of these patients their mental health review did not include the recording of all relevant data. For example, a record of the patient's blood pressure or Body Mass Index (BMI) or their smoking status.

At our inspection in April 2019 performance for mental health and dementia related indicators was higher than local and national averages. However, exception reporting for the dementia related indicator was also much higher than local and national averages. Staff told us that this was due to the practice having only three patients who were diagnosed with dementia. They had all been offered and encouraged to attend, with their carers, for a face to face review. However, only two had taken up this

offer.

At our inspection in June 2021 performance for mental health and dementia related indicators was higher than local and national averages. However, exception reporting for the dementia related indicator was also higher than local and national averages. Records showed that there were four patients registered at the practice who were diagnosed with dementia and that all had received a dementia review within the last 12 months. However, for one of these patients, whose records showed their review had been carried out in November 2020, we looked but could not find evidence to show that they had been offered breast or bowel cancer screening or a pneumococcal vaccination.

After our inspection the provider wrote to us with evidence to show that there were now only three patients registered at the practice who were diagnosed with dementia. Records showed that all three had received a face to face review within the last 12 months.

Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	96.2%	83.1%	85.4%	No statistical variation
PCA rate (number of PCAs).	7.1% (2)	18.8%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	100.0%	78.1%	81.4%	No statistical variation
PCA rate (number of PCAs).	50.0% (1)	9.5%	8.0%	N/A

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

There was an induction programme for new staff.	Yes
The learning and development needs of staff were assessed.	Yes
All staff were up to date with essential training.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation.	Yes
Clinical staff 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 approach for supporting and managing staff when their performance was poor or variable.	Yes
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Coordinating care and treatment

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

Indicator	
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centered care when they moved between services.	Yes

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives. However, improvements in the recording of the care and treatment of patients receiving palliative care were required.

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.	Partial
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

Additional evidence or comments

Records showed that two patients registered at the practice were receiving palliative care. For one of these patients, we looked but could not find evidence of a clear diagnosis or a discussion / decision regarding their resuscitation status in their computerised records. This patient's records showed that they had been reviewed in February 2021. However, we looked but could not find evidence to show that and further reviews had taken place since then. For the other one of these patients, records showed that they had been referred to a hospice on 12 April 2021. However, we looked but could not find evidence of a discussion / decision regarding their resuscitation status or any other follow up by the practice in their computerised records.

After our inspection the provider wrote to us and told us that one of the patients on the practice's palliative care register should not have been on this register. They also told us that the other patient

on the palliative care register had now had their care and treatment reviewed.

Records showed that the practice had identified 13 patients on the practice register who were carers (1% of the practice list). The practice had a system that formally identified patients who were also carers and written information was available to direct carers to the various avenues of support available to them. The practice's computer system alerted staff if a patient was also known to be a carer.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance. However, improvements in the recording of patients' resuscitation statuses were required.

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.	Partial

Additional evidence or comments

Records showed that, following appropriate discussion, the decision had been made that two patients registered at the practice had been made not for resuscitation. One of these patients had this decision recorded on the recognised relevant DNACPR form which was saved into their computerised records. Although the discussion had been recorded in the other patient's computerised records as part of their personal care plan, we looked but could not find evidence that the decision had been recorded on the recognised relevant DNACPR form.

Well-led

Rating: Requires Improvement

We rated the practice as Requires Improvement for providing well-led services because:

- There was compassionate and inclusive leadership at all levels.
- The practice had a vision to deliver high quality care and promote good outcomes for patients.
- There were processes and systems to support good governance and management.
- The practice's processes for managing risks, issues and performance were not always effective.
- Backlogs in relation to cancer screening were in the process of being addressed by the practice.
- The practice engaged with the public, staff and external partners and was in the process of reinstating a patient participation group.

Leadership, capacity and capability

There was compassionate and inclusive leadership at all levels.

Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
Leaders 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
Additional evidence or comments	
Local leadership was led by the area lead GP Partner. All staff were supported by the Sydenham House Medical Group management team.	
Staff told us that they were able to manage and develop services locally, to help meet the needs of the practice patient population, and that they were supported in doing so by the Sydenham House Medical Group management team.	
Staff told us that the area lead GP partner and practice management were approachable and always took time to listen to all members of staff. They also told us that they were able to approach the Sydenham House Medical Group management team for help and support.	
Staff said that leadership at the practice was open, transparent and inclusive.	

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients.

The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
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
Additional evidence or comments	
The provider had a statement of purpose which reflected the visions of the practice.	

Culture

The practice had a culture of high-quality sustainable care.

Staff told us there was an open culture within the practice and they felt confident and supported to raise any issues.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
Additional evidence or comments	
Staff told us they felt respected, valued and supported locally by the practice and by their colleagues. They also told us that felt supported by the Sydenham House Medical Group management team.	

Governance arrangements

There were processes and systems to support good governance and management.

There was a clear staffing structure and staff were aware of their own roles and responsibilities.	Yes
The provider had systems that helped to keep governance documents up to date.	Yes
Governance documents that we looked at were up to date.	Yes

Managing risks, issues and performance

The practice's processes for managing risks, issues and performance were not always effective.

There were effective arrangements for identifying, recording, managing and mitigating risks.	No
There were processes to manage performance.	Yes
Clinical and internal audit was used to monitor quality and to make improvements.	No
Records showed that the provider had analysed all clinical audit results and implemented action plans to address findings.	No
Records showed that all clinical audits had been repeated or were due to be repeated to complete the cycle of clinical audit.	No
There was written guidance for staff to follow in the event of major incidents that contained emergency contact telephone numbers.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes

Additional evidence or comments

At our inspection in June 2021 the provider was unable to demonstrate their processes and systems were effective in the management of risks from: the practice's computer system not alerting staff of all family and other household members of children that were on the risk register and adults on the vulnerable adult register; management of appropriate authorisations to allow staff to administer medicines; and management of the prescribing of some high-risk medicines.

At our inspection in April 2019 some processes to manage current and future performance were not yet sufficiently effective. For example, improvements to childhood immunisation uptake rates as well as breast and bowel cancer screening uptake rates, improvements to and the monitoring of staff application of read codes to patients' computerised records, were ongoing.

At our inspection in June 2021 we found that some processes to manage current and future performance were still not sufficiently effective. This was partly due to limitations imposed on services by the pandemic. For example, breast and bowel cancer screening was suspended by Public Health England for a time during the pandemic. The practice also had to adapt the way they delivered services during the pandemic to reduce the risks from COVID-19 to patients and staff. For example, at the height of the pandemic the practice risk assessed patients who were eligible for cervical screening and restricted the offer of screening to those patients at high risk of cervical cancer only. However, improvements to care and treatment were required for some types of patient reviews and well as subsequent follow-up activities. For example, asthma reviews, hypertension reviews, atrial fibrillation reviews, and mental health reviews (including dementia). Improvements were also required to the recording of the care and treatment of patients receiving palliative care as well as the recording of patients' resuscitation statuses.

At our inspection in April 2019 we found that four completed clinical audit cycles had been carried out. However, there was little or no clinical improvement as a result of the audits. For example, a medicine audit carried out in October 2018 found that only two patients, out of the six that were included in the audit, had been correctly prescribed a particular antibiotic. This audit was repeated in January 2019

and found that there had been no improvement since the first audit. Another medicine audit carried out in September 2019 resulted in an action plan to invite one patient, who was on a specific medicine, into the practice for a medicine review. This audit was repeated in January 2019 and found that the patient had not been contacted by the practice since the first audit.

At our inspection in June 2021 staff told us that no clinical audits had been carried out during the last 12 months due to the additional pressures caused by the pandemic and varying staffing levels during the pandemic. There were plans to carry out clinical audits in the next 12 months to help monitor and improve performance where necessary. For example, an audit of the care and treatment of patients with gestational diabetes, an audit of patients coded as alcohol dependent and an audit of the review of patients prescribed folic acid.

After our inspection the provider wrote to us with evidence to show that the audit of patients coded as alcohol dependent had been carried out as planned in July 2021. Results showed that four of these patients met the criteria to be prescribed treatment. The provider told us that these patients had now been contacted and relevant treatment (medicine) prescribed. Records also showed that the audit was due to be repeated in three to six months time.

The provider had systems to continue to deliver services, respond to risk and meet patients’ needs during the pandemic.

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 to help 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 to help 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
Additional evidence or comments	
A single point of contact was introduced by the provider for practice staff to refer to with any concerns related to COVID-19 during the pandemic.	
Backlogs in relation to cancer screening (cervical, breast and bowel) were in the process of being addressed by the practice.	

Appropriate and accurate information

The practice acted on appropriate and accurate information.

Quality and operation information was used to help monitor and improve performance.	Yes
The provider submitted data or notifications to external organisations as required.	Yes
There were arrangements in line with data security standards for the integrity and confidentiality of patient identifiable data, records and data management systems.	Yes

Governance and oversight of remote services

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.

Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	No
The practice gathered feedback from patients through the patient participation group.	No
The practice gathered feedback from patients through analysis of the results of the national GP patient survey.	Yes

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
Additional evidence or comments	
<p>Prior to the pandemic the practice had a small but active Patient Participation Group (PPG). Members of the PPG did not wish to hold meetings during the pandemic and had chosen to wait until the pandemic was over before reconvening meetings (virtual or otherwise). Staff told us that now that the practice was no longer subject to all COVID-19 related restrictions (i.e. reception was now open to patients again) they were trying to recruit more patients to the PPG. For example, there was a recruitment leaflet available in the waiting room that informed patients how to join the PPG. This information was also displayed on the practice's website.</p> <p>After our inspection the provider wrote to us and told us that they have now managed to recruit five new members to their PPG.</p> <p>Staff told us that feedback was gathered from patients through the monitoring of results from the Friends and Family Test as well as monitoring feedback left on the NHS Choices website.</p>	

Continuous improvement and innovation

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

There was a focus on continuous learning and improvement.	Yes
The practice made use of reviews of incidents.	Yes
Learning was shared effectively and used to make improvements.	Yes
Additional evidence or comments	
<p>Significant events and complaints were used to make improvements and any learning shared with relevant staff. For example, staff had received specific training following complaints about issues with repeat prescriptions.</p>	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **PHE:** Public Health England.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)).
- ‰ = per thousand.