

Inspection Evidence Table

Bacon Road Medical Centre

(1-572313749)

Inspection Date:

Date of data download: 19 April 2023

Overall rating: Requires improvement

We previously inspected Bacon Road Medical Centre on 24 August 2022, report published 11 October 2022 and the practice was rated inadequate overall and placed in special measures. As a result of the concerns identified, we issued a Section 29 warning notice on 30 August 2022 in relation to a breach of Regulation 12 Safe Care and Treatment, requiring them to achieve compliance with the regulation by 18 October 2022. We undertook a focused inspection on 26 October 2022 to check that the practice had addressed the issues in the warning notice and now met the legal requirements.

At this inspection we have rated the practice as requires improvement because;

We found the practice had made significant improvements, and the trajectory of the practice action plan was positive. Although some improvements, systems and processes were implemented, they needed further embedding and monitoring to ensure they were sustainable and effective. We found the GP partners had strengthened their leadership and worked with the management team. Evidence we saw showed there was clear clinical leadership and better cohesive working, resulting in improved systems and processes and working practices. There was greater knowledge of the areas where risks were identified and the actions required. Processes to enable monitoring and oversight had been improved. The management team had developed clearer roles and responsibilities to ensure quality checks and improvements were monitored appropriately.

Safe

Rating: Requires improvement

At our last comprehensive inspection published October 2022, the practice was rated as inadequate for providing safe services because:

- The practice did not have a recruitment process in place which ensured staff had been recruited safely.
- The practice did not have oversight of the immunisation status of staff.
- The practice used some risk assessments to manage the health, safety and welfare of patients and staff but these had not all been monitored or used effectively.
- We found the practice's system for managing patient and medicines safety alerts did not ensure medicines were prescribed safely.

- The practice did not evidence that all patients had received a structured and comprehensive medicines review. We saw that reviews had been coded on the clinical system but there was no evidence in the clinical records of a structured medicines review or consultation with the patient.
- We reviewed patient consultation records and found discrepancies with the coding of medical records.
- We found the practice did not evidence clear supervision and competency checks for all staff.
- We found the practice did not have an effective system or process to process and manage oversight of test results, to monitor out of range fridge temperatures and to monitor dispensary room temperature to ensure medicines are safe for use.

At this inspection we have rated the practice as requires improvement for providing safe services because;

- We found the practice had made improvements but some of the systems and processes had not been fully embedded, nor had all full improvements been achieved. However, we were assured that actions had been identified and the practice was continuing to complete all outstanding areas of improvements needed.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y ¹
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y ²
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: <ol style="list-style-type: none"> 1. At our last comprehensive inspection, not all staff were trained to the appropriate level for their role. At this inspection, we saw all staff had undertaken appropriate training. 2. At our last comprehensive inspection, not all staff had received a DBS check. At this inspection we saw the practice had implemented a system to ensure all staff had a DBS check and the employment system was changed to ensure all new staff members were assessed and, where appropriate, a DBS check undertaken and recorded. 	

Recruitment systems	Y/N/Partial
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Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y ¹
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y ²
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> At our last comprehensive inspection, we found the practice system and process to ensure all staff had received a DBS check had failed. At this inspection, we found all staff had received a DBS check and the system had been strengthened to ensure all new staff members would be assessed and a DBS check undertaken if required. At our last comprehensive inspection, the practice did not have oversight of the immunisation status of staff. At this inspection, we found the practice had undertaken a programme to engage with staff to record their immunisation status and where necessary, had included an occupational health assessment. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	P ¹
Date of last assessment: October 2022	Y
There was a fire procedure.	Y
Date of fire risk assessment: October 2022	Y
Actions from fire risk assessment were identified and completed.	P ²
<p>Explanation of any answers and additional evidence:</p> <p>1&2 At the last comprehensive inspection, we found the practice had not undertaken comprehensive reviews of the fire risk assessment nor health and safety within the practice. At this inspection, we found the practice had improved the quality of the assessment and their understanding of the actions required. However, we found the practice had only recently started the action plan and some improvements had not been fully made or embedded. For example, completing documentation such as a floor plan identifying area of elevated risk, for example where the oxygen cylinders were stored was in progress and not yet finished. The practice had a lead person to ensure clear oversight of risk assessments and to ensure all actions were completed and staff aware of the changes.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y ¹
Date of last infection prevention and control audit:	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y ²
The arrangements for managing waste and clinical specimens kept people safe.	Y ³

Explanation of any answers and additional evidence:
 1&2 At our last comprehensive inspection we found the practice was unable to evidence an infection prevention control (IPC) audit or sufficient information to assure that IPC was managed. At this inspection, we found this had been improved and a comprehensive audit had been undertaken. The practice had a greater awareness of the areas that still required improvement such as areas with carpet flooring. The practice had a plan and were reviewing this regularly to ensure all actions identified were completed.
 3 At our last comprehensive inspection, we found a lack of clear process for the safe management of clinical waste. At this inspection, staff we spoke with were clear about the roles and responsibilities and the safe management of clinical waste.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y ¹
There was an effective induction system for temporary staff tailored to their role.	Y ²
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> At our last comprehensive inspection, we found the practice had a backlog of 332 records to fully summarise; at this inspection the practice told us they had been working to reduce this although they still had a backlog of 300 records, some of which were new patients. They told us the backlog dated to September 2022 and therefore had improved since the last inspection. The practice told us they continued to address this area of work and had trained additional staff to do this. The practice had addressed any unfiled tasks and had systems in place to ensure all GPs clinical work was covered by GP colleagues if they were absent from the practice. The practice had improved the locum pack available to GPs who provided services at the practice. 	

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.	P ¹
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y

Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y ²
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. At the last comprehensive inspection, we reviewed some patient records and we found inconsistencies in the quality of record keeping and coding for medical records. At this inspection, we found this had improved although we still found some inconsistencies in the record keeping. For example, not all medicines reviews had been coded using the same code. This did not allow the practice to have clear and easy oversight of the monitoring required for all patients. The practice shared with us the plans they were working with to further improve this. Staff we spoke with told us this was work in progress but there was better understanding and monitoring of the quality of record keeping. 2. At the last comprehensive inspection, we found the practice did not have systems and processing in place to ensure all test results were filed appropriately. At this inspection, we found this had improved and the practice had implemented systems to ensure the filing of electronic test results was completed in a timely manner. 	

Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHSBSA)	0.91	0.93	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2021 to 30/09/2022) (NHSBSA)	7.0%	10.4%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2022 to 30/09/2022) (NHSBSA)	5.23	5.77	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	216.5‰	197.8‰	129.6‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related	1.82	0.93	0.58	Variation (negative)

Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHSBSA)				
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	19.9‰	12.1‰	6.7‰	Significant variation (negative)
<p>Explanation of any answers and additional evidence:</p> <p>The practice told us they had implemented systems and process to monitor prescribing of medicines. We noted that the practice had undertaken reviews and changes to some prescribing and had reduced the variation for the prescribing of Hypnotics. At our previous inspection the practice performance 1.91 compared with the CCG average of 0.99 and national average of 0.60.</p> <p>The practice performance for prescribing of psychotropics had also improved. At our last inspection the performance was 23.0‰ compared to the CCG 12.2‰ and national 6.8‰</p>				

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y ¹
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	P ²
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	P ³
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y ⁴
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y

For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y ⁵
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ol style="list-style-type: none"> At our last comprehensive inspection, the practice was not able to provide evidence of clinical supervision and oversight of medicines prescribed by non-medical prescribers. At this inspection, we saw that a system and process to undertake consultation reviews, including audits of prescribing had been put into place. The practice had included looking at the quality of care delivered by locum GPs as well as those directly employed. At our last comprehensive inspection, the practice did not evidence that there was a clear and effective system to ensure patients on repeat medicines were reviewed and all medicines they were taking had been considered. At this inspection, we found the practice had introduced improved templates, so all information was recorded in a consistent manner. They had held meetings with clinical staff to make the staff with a prescribing qualification aware of the template and how it should be used. This new system required further embedding and time to be able to reflect it is wholly effective as the practice are still working through the back log of medicines reviews. The practice undertook regular reviews to ensure the new processes were being followed. At our last comprehensive inspection, we found the practice systems and processes had failed to ensure all patients were prescribed medicines safely and a warning notice was issued. At our last focused inspection where we followed up on the breaches detailed in the warning notice; we found the practice had made the necessary improvements. At this inspection, we found the systems and processes the practice had implemented to ensure patients were recalled for reviews and as appropriate blood tests was in progress. With the consent of the practice, we undertook further clinical searches relating to medicines that required monitoring and review. We found; <ul style="list-style-type: none"> 24 patients had been prescribed a medicine, Methotrexate; our search indicated 5 patients were potentially overdue appropriate monitoring. We reviewed all 5 of these patients and found 1 patient was overdue. The practice took immediate action and contacted the patient. 21 patients had been prescribed a potassium sparing diuretic. Our search indicated 5 patients had not received the appropriate monitoring. We reviewed 5 patients records and found 1 of the 5 was overdue monitoring. During discussion with the practice, we found the other 2 patients had been monitored but the results had not been downloaded from the hospital system or extracted from a hospital clinical letter and recorded in the practice records. The practice told us this was an area they had on their action plan to review and implement systems to address this. Some of this relied on training new staff to undertake this work. At our last comprehensive inspection, we identified areas of risk relating to the prescribing of controlled drugs. The practice did not have a system in place to prevent over ordering and did not meet the legal requirement for controlled drug prescribing. We looked at 5 out of the 18 patients prescribed Gabapentinoids who did not have a medicines review in the last 12 months and found that all five patients had not had a review in the past 12 months. At this inspection, we found improvements and awareness had been improved as at our last comprehensive inspection our search found 130 patients prescribed Gabapentinoids. The practice showed they were aware of this area of work and a GP was undertaking this work for the practice and on behalf of the ICB to share wider learning and support GPs to review and reducing prescribing where appropriate. 	

5. At our previous full comprehensive inspection, the practice did not demonstrate an effective system for monitoring the temperatures of vaccine fridges and room temperatures. At this inspection we found the new systems had been put in place and regular review was undertaken to ensure medicines were stored safely.

Track record on safety and lessons learned and improvements made.
The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	6
Number of events that required action:	6
Explanation of any answers and additional evidence: The practice used an online system where a template was provided to report significant events. Staff told us they felt able to raise concerns and were confident with the system in place. However, the process had not been wholly effective as some events had not been recorded with sufficient detail to ensure an appropriate	

investigation, actions that were required and learning was shared. We discussed this with the practice who told us they would review the clinical governance oversight, the system and implement more staff training.

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

Event	Specific action taken
Delay in medicine being prescribed	Email informing the patient/carers that a change of medicine was required was sent to the wrong email address. The detail of the investigations and actions was still in progress. However, there was a protracted delay on this as staff had not fully completed the event investigation process.
Potential of delay in prescribing a medicine	A clinical staff member identified from a letter that a patient required medicines prescribed. The administration progress had not highlighted this as per the practice policy. Immediate action was taken, there was no risk to the patient as the error had been found within 48 hours.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>The practice told us safety alerts were received via email and an online system. They were then actioned by a clinical pharmacist and a dispensary lead who alerted staff via an online system where acknowledgement is requested, they then conducted searches, taking appropriate action. The alerts were also discussed at clinical meetings. As part of our clinical searches, we reviewed safety alerts that may affect patients. An alert we looked at related to the patients prescribed a medicine which may increase the risks during pregnancy. Our search identified 25 patients could be affected by this alert and we reviewed 5 of these patient records. We found evidence that the risks had been discussed with the patients. The practice told us the new systems in place included regular monitor of alerts and the findings.</p>	

Effective

Rating: Requires Improvement

At our previous comprehensive inspection, the practice was rated as inadequate for providing effective services because:

- Patients' needs were not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance.
- Patients with long term conditions had not been proactively monitored.
- We found examples where clinical coding was missing from patient records or the clinical coding applied was not wholly accurate. The poor-quality coding of patient records meant that patients' needs were not always identified and therefore they were not always given appropriate or necessary care and treatment.

- The practice failed to have an effective system in place for recalling, monitoring or treating patients with asthma and hypothyroidism. This did not ensure these patients received the appropriate care to meet their needs.
- The practice had limited use of data and information from its clinical record system to drive improvements and monitor care.
- We found no evidence of competency checks, nor did staff have regular appraisals. Therefore, we could not be assured there were effective systems in place to ensure good quality care and treatment was delivered.

At this inspection we found the practice had made improvements but some of the systems and processes had not been fully embedded, nor had all full improvements been achieved. However, we were assured that actions had been identified and the practice was continuing to complete all outstanding areas of improvements needed.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y ¹
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	P ²
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	P ³
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:	
1. At our previous comprehensive inspection, our searches identified over prescribing of controlled drugs, therefore we could not be assured that the systems in place to keep clinicians up to date with current evidence-based guidance were effective. At this inspection, we found the practice had implemented regular searches to ensure all prescribing of controlled drugs was reviewed appropriately.	
2 At our previous comprehensive inspection, our searches identified we reviewed records of 5 patients on the asthma register and we found in all 5 records there was no evidence of an asthma care plan. We also	

reviewed records of 5 patients with dementia. We examined 5 patient records and found that 4 of the 5 patient records had no dementia care plan in place. During the clinical searches we found inconsistent coding in medical records and medicines had not been linked to conditions. Therefore, we could not be assured that the practice had effective systems in place to assess the needs of their patients. At this inspection, we found the consistency of record keeping had improved, however, we reviewed 5 patients records and found they had been prescribed steroid medicines following an exacerbation of asthma had not all been followed up within the appropriate time frame. We spoke with the practice who confirmed they had a system, but it had not been fully embedded and monitored. They had this on their action plan and were in the progress of making the changes.

3 At our previous comprehensive inspection the clinical searches undertaken identified ineffective medicine reviews due to inconsistent coding and the poor linking of medicines to conditions. There was insufficient detail to be assured all medicines had been assessed and the patients ongoing needs had been managed safely. At this inspection, we found systems and processes had been implemented to ensure coding and linking medicines to diagnosis was being completed. We noted that this will require sufficient time for the improvements to be made to show effective and sustained changes, enabling easy access to accurate information.

Effective care for the practice population

Findings

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty.
- Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. The practice told us they had identified 915 patients who were eligible for a health check, of these, the practice had completed 154 (16%) NHS health checks.
- All patients with a learning disability were offered an annual health check. The practice told us they had identified 11 patients who were eligible and of these, (36%) health checks had been completed. The practice told us they had a programme in place to ensure all patients with a learning disability were reviewed and supported during the year.
- 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.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- At our last comprehensive inspection, we found not all patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. At this inspection, we found this had improved. The practice had a new recall system in place and their action plan showed all patients would be reviewed within the year from the month of their birth date. Staff we spoke with said they found this a positive way to manage patients and to co-ordinate their needs for more than one check using the minimum number of appointments.
- At this inspection our clinical search identified 30 patients with a diagnosis of asthma had been prescribed rescue steroids in case they required them. We reviewed 5 records and found that all 5 patients had not been followed up within an appropriate timeframe. We discussed this with the practice who told us they had implemented a new system and recording template to ensure that patients were followed up by the prescribing clinician. They told us this system needed further improvement and embedding to ensure all staff adhered to the appropriate timeframes for follow up.
- Our clinical searches identified 34 patients with a diagnosis of diabetes and with diabetic retinopathy who had not received appropriate follow up within the past 12 months. Our search found 34 patients, we reviewed 5 patient records and found 2 were overdue appropriate monitoring. The practice took action and reviewed these patients.
- The practice shared information with relevant professionals when deciding care delivery for patients with long-term conditions. This had been more effective as the coding of medical records was more accurate and consistent.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. However, our searches identified 27 patients with a potentially missed diagnosis of chronic kidney disease (CKD 3-5). We reviewed 5 patient records and found 4 had not been identified and coded with CKD. We spoke with the practice who told us and shared evidence that this was an area of work they were currently addressing through their action plan. Our clinical searches showed all patients with chronic kidney disease stages 4 or 5 had been reviewed appropriately.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.

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) (UKHSA COVER team)	44	45	97.8%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received	43	47	91.5%	Met 90% minimum

Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (UKHSA COVER team)				
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (UKHSA COVER team)	43	47	91.5%	Met 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) (UKHSA COVER team)	43	47	91.5%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (UKHSA COVER team)	53	57	93.0%	Met 90% minimum

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

Any additional evidence or comments
The practice had met the target on 5 indicators and was over 95% on 1 indicator. The practice had appointments available throughout the day allowing for flexibility.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	62.5%	70.4%	66.8%	N/A
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	61.4%	70.2%	61.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	68.8%	54.4%	54.9%	No statistical variation
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (30/06/2022 to 30/06/2022) (UKHSA)	73.2%	N/A	80.0%	Below 80% target

Any additional evidence or comments
At our last comprehensive inspection, the practice performance for 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) was 71.6% at this inspection. This had increased to 73.2%.

Monitoring care and treatment

The practice had an improved programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided/There was limited monitoring of the outcomes of care and treatment.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:	

Any additional evidence or comments

The practice demonstrated an improved approach to the use of audits and searches to monitor and improve services to patients. As part of the action plan where changes were made or risks identified, the practice used regularly monitoring for example, whilst managing the risk for missed diagnoses, a regular search was undertaken to manage these patients, identifying any new patients who may be affected and to ensure sufficient resources were available to contact the patients. The practice had improved the recording of quality competency checks to ensure shared learning was easily identified and provided. Staff we spoke with found the new improved approach to using audits and searches was positive.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y ²
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y ³

The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y ⁴
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: 1,2,3&4 At our previous inspection we found the practice had an inconsistent approach to the coding of medical records. We found indication plans were not role specific, that staff had not had regular appraisals and competency checks were not undertaken or documented. At this inspection, we found the practice had made improvements. The coding of medical records had improved although needed further embedding and monitoring to ensure a consistent accurate approach at all times. We saw staff induction templates were prepared that were role specific and competency checks undertaken.	

Coordinating care and treatment

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

Helping patients to live healthier lives.

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

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

Any additional evidence or comments

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Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient’s mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<p>Explanation of any answers and additional evidence</p> <p>At our previous comprehensive inspection, we reviewed medical records of some patients with a diagnosis of dementia. We found in all cases that there was no evidence of a historic review or mental capacity assessment. At this inspection, records we reviewed contained evidence to show the patient capacity had been assessed appropriately.</p>	

Caring

Rating: Good

Kindness, respect and compassion

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

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

Patient feedback	
Source	Feedback
CQC Share my care feedback from patients	.Since the last inspection 12 patients sent feedback. These? 1 reported poor care given by staff. 4 of the 12 comments said they had found staff caring.
Care home representatives	Feedback we received from care home representatives we spoke with told us that staff were caring towards the patients, carers and relatives.

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	88.3%	86.4%	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)	87.1%	85.8%	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)	95.6%	94.5%	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)	75.0%	75.7%	72.4%	No statistical variation

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

Any additional evidence

. The practice used the Friends and Family Test (FFT) to gain feedback from patients. They also reviewed the data from the NHS choices website, complaints and compliments they received from patients.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: Easy read and pictorial materials were available.	

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	95.1%	92.0%	89.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 174 (3.6%) patients as carers, they were able to identify those carers who were young or those that required additional support themselves.
How the practice supported carers (including young carers).	The practice referred carers to support agencies and offered priority appointments and flu vaccinations to carers.
How the practice supported recently bereaved patients.	Bereaved patients were signposted and referred to bereavement counselling and bereavement support groups. The practice had further information available to support recently bereaved patients.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Agree Good

Responsive

Rating: Good

At our last inspection we rated the practice as good for providing responsive services. At this inspection that rating remained good. Please note the GP patient survey data is the same data as used in our previous full comprehensive report.

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Practice Opening Times	
Day	Time
Opening times:	
Monday	8:00am – 6pm
Tuesday	8:00am – 6pm
Wednesday	8:00am – 6pm
Thursday	8:00am – 6pm
Friday	8:00am – 6pm
Appointments available:	
Monday	8:00am – 6pm
Tuesday	8:00am – 6pm
Wednesday	8:00am – 6pm
Thursday	8:00am – 6pm
Friday	8:00am – 6pm

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	P ¹
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	P ²
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<p>Explanation of any answers and additional evidence: 1,2 Feedback we reviewed from CQC share my care in respect of access to the surgery was mostly negative, common themes were long waiting times on the phone and being directed to A+E even though it was not an emergency or life-threatening concern. The practice had taken some actions and adjusted their phone lines and staffing arrangements to improve their performance. These changes had not been in long enough to impact on the patient's feedback as yet. The practice was confident that the changes would be reflected in a more positive experience for patients.</p>	

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
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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)	75.0%	N/A	52.7%	Variation (positive)
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)	71.0%	61.7%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	74.0%	59.8%	55.2%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	85.7%	77.0%	71.9%	Tending towards variation (positive)

Source	Feedback
NHS.uk website (formerly NHS Choices)	There was one review made within the last 12 months on the NHS website, the review was positive and stated they were offered an appointment within 20 minutes of calling.

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.	.6
Number of complaints we examined.	2.
Number of complaints we examined that were satisfactorily handled in a timely way.	.2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	.0

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

Example(s) of learning from complaints.

Complaint	Specific action taken
Registering with the practice. Practice tried to call once	Reviewed system and process and discussed with staff

Practice only called back patient once	Practice reviewed system and have made changed to phone patient a second time if they did not answer the first call.
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Well-led

Rating: Requires improvement

At our previous comprehensive inspection, the practice was rated as inadequate for providing well led services and placed in special measures because;

- The leadership team were unable to demonstrate there were effective governance systems and processes to ensure the delivery of safe and effective care.
- We found a lack of clinical oversight was in place from the provider to fully support staff to deliver safe care and treatment to patients.

At this inspection we have rated the practice as requires improvement for providing well led services because.

- We found the practice had made significant improvements and the trajectory of the practice action plan was positive. Although some improvements, systems and processes were implemented, they needed further embedding and monitoring to ensure they were sustainable and effective. We found the GP partners had strengthened their leadership and worked with the management team. Evidence we saw showed there was clear clinical leadership and better cohesive working resulting in improved systems and processes and working practices. There was greater knowledge of the areas where risks were identified, and the actions required. Processes to enable monitoring and oversight had been improved. The management team had developed clearer roles and responsibilities to ensure quality checks and improvements were monitored appropriately.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
<p>Explanation of any answers and additional evidence: Throughout the inspection we saw the practice had worked with the ICB (Integrated Care Board) to develop an action plan to prioritise the areas that needed improvement. New systems and processes were in place, some needed further time to show they were completed and were fully effective and sustained.</p>	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: Most staff we spoke with told us there was a clear strategy in place, but some staff reported they found some of the management communication confusing. We spoke with the management team who understood this and told us the development of new roles was a work in progress and relied on staff having additional training. All staff told us they had seen improvements within the practice.	

Culture

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

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

Source	Feedback
Staff questionnaires and staff we spoke with	Staff told us that they have been working as a cohesive team to make the necessary improvements. Some staff reported that since as a result of these improvements they felt the patients and themselves and colleagues were working in a safer environment. Some staff told us they felt there were still further improvements that could be made, including better communication and they were keen to be part of this.

Governance arrangements

The responsibilities, roles and systems of accountability to support good governance and management had been improved. However, some needed to be further improved, embedded and monitored to ensure they were effective and sustained.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	P ¹
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	P ²
Explanation of any answers and additional evidence: 1&2. The practice was aware that some of their systems and processes needed more time to be fully implemented and embedded to meet all the improvements detailed in their action plan developed following our last comprehensive inspection. These included completing actions required from risk assessments such as fire and legionella, continuing to ensure medicine reviews were effective and that coding of medical records was accurate and consistent. The system and process to ensure all significant events were investigated thoroughly and appropriate actions was not effective. The practice told us significant staff training and support was now in place to ensure these improvements would be fully made and that the systems and processes in place would ensure good governance at all times.	

Managing risks, issues and performance

There were processes for managing risks, issues and performance, some of these were newly implemented and needed time to show they are effective and sustained.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	P ¹
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: 1. At our last inspection we found the assurance system in place failed to identify that the monitoring and prescribing of controlled drugs, clinical coding, risk assessments, monitoring of medicines and staff vaccinations were not being managed effectively. The practice had started audits but were unable to provide full cycles and if improvements had been made. The practice did not have a comprehensive and documented approach to quality improvement which would have supported identifying shortfalls and risks to patients. At this inspection we found the practice had made improvements in all these areas. The practice told us they needed further time to fully embed these and show they were effective and maintained.	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y

Governance and oversight of remote services

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Feedback from Patient Participation Group.

Feedback

. The practice had a newly revived PPG group who had been meeting regularly. We spoke with members of the group who told us they found the attitude of the practice staff was positive towards them. They told us staff listened and engaged with their feedback. The PPG members told us they had seen improvements with the practice and were positive about continuing to work with the practice leaders.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	

Examples of continuous learning and improvement

Through this inspection, the practice evidenced that they had a renewed approach to learning and improvement. They had worked with the external ICB and as a cohesive team to have open conversation and to find solutions. For example, the practice had continued to use and modify the clinical searches used by the CQC to ensure patients received safe treatments and medicines. Staff training had been completed and additional supervision and checks were in place.

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.
- **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.