

## Inspection Evidence Table

Tollgate Health Centre

(1-6161134058)

**Inspection Date: 26/09/2023**

Date of data download: 25/09/2023

## Overall rating: Good

At the last inspection on 11 February 2022, we rated the practice as Requires Improvement overall because we found:

The practice had made improvements and acted on all the issues identified. We rated Caring and responsive key questions rated requires improvement as further improvements regarding access and patient satisfaction were still required. Safe, effective, and well-led key questions were rated as good following the completion of the improvements made since the last inspection.

At this inspection we found:

The improvements made at the previous inspection had been embedded. The actions taken and areas of improvement with access and patient satisfaction within caring and responsive relating to the GP patient survey were now embedded and effective with all indicators in the majority being above local and national averages.

## Context

The practice population is approximately 9,500.

Information published by Public Health England shows that deprivation score is eight showing the practice is less deprived than others in the Northeast Essex Area. The lower the decile, the more deprived the practice population is relative to others. According to the latest available data, the ethnic make-up of the practice area is 2.6% Asian, 94.7% White, 0.7% Black, 1.5% Mixed, and 0.5% Other. The practice population has a higher number of young families and less over 65 years olds compared with local and national averages. The life expectancy of female and male patients is higher than local and national averages.

The practice had experienced some nursing staff losses and were in the process of recruiting two nurse practitioners.

# Safe

Rating: Good

## Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
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
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: <ul style="list-style-type: none"><li>• When we spoke with staff, they were able to tell us who the named safeguarding lead was at the practice. We were provided evidence that the safeguarding lead attended the regular local safeguarding meetings.</li><li>• The practice safeguarding policies had been reviewed and updated for both adults and children.</li></ul>	
Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• We found evidence that disclosure and barring service (DBS) checks had been carried out for all staff working at the practice.</li><li>• We were provided evidence of staff vaccination status relevant for their roles, and assurance of clinical staff registration details.</li></ul>	
Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y

Date of last assessment:	Y 09/05/2023
There was a fire procedure.	Y
Date of fire risk assessment:	Y 09/05/2023
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• There were no risks or actions identified following the health and safety risk assessments.</li> <li>• The actions following the fire risk assessments regarding signage needing to be added to the sliding doors to ensure escape routes were easily accessible had been carried out.</li> </ul>	

### Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met.**

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit:	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y 25/09/2023
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Staff had received the training and information to minimise infection prevention and control (IPC) risks to staff and patients.</li> <li>• Actions had been taken following the annual audit for example, all soap dispensers wall mounted, storage bin concerns with the landlord addressed, new comprehensive cleaning schedules in place for both clinical staff and cleaners.</li> </ul>	

### Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y

There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
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### Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients. For example, history, examination, management plans, safety netting and follow up was adequately documented within the patient record.</li> <li>We saw workflow was well managed and test results were acted on in a timely manner.</li> </ul>	

### 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) (01/07/2022 to 30/06/2023) (NHSBSA)	1.10	1.08	0.91	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). (01/07/2022 to 30/06/2023) (NHSBSA)	10.9%	8.0%	7.8%	Tending towards variation (negative)
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 (01/01/2023 to 30/06/2023) (NHSBSA)	5.45	5.70	5.24	No statistical variation

Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) <small>(NHSBSA)</small>	116.7‰	185.8‰	129.6‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) <small>(NHSBSA)</small>	0.90	0.99	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) <small>(NHSBSA)</small>	7.0‰	12.0‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	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
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. 2	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	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
Explanation of any answers and additional evidence, including from clinical searches.	

- We found medicines were stored safely and securely with access restricted to authorised staff.
- Controlled drugs were monitored for example, investigation of unusual prescribing, quantities, dose, formulations, and strength.
- The practice was working with the local medicines management team to reduce the antibiotic prescribing as this had shown a 0.9% increase since in the last year.
- The practice held appropriate emergency medicines, we found there were processes in place to monitor stock levels, temperature control and expiry dates.

The review of patient records in relation to the clinical searches identified:

- All the patients at the practice taking disease modifying antirheumatic medicines (DMARDs) had received appropriate monitoring.
- Patients prescribed high risk medicines (for example, warfarin, methotrexate, and lithium) had received appropriate monitoring and clinical reviews.
- Of the 781 patients taking angiotensin converting enzyme medicines (ACE) inhibitors 5 had not received some of their required monitoring. However, when we reviewed the 5 sets of records 1 patient had received their monitoring and follow-up in Secondary Care, 1 patient was booked for their blood test, and 3 were long term non responders. They had reduced the amount of medicine the patient could order on a repeat prescription to encourage them to attend for monitoring.
- We searched 5 sets of records from the 136 patients taking sodium glucose cotransporter 2 inhibitors (SGLT-2) to check they had been provided advice regarding diabetic ketoacidosis (DKA) and Fournier's gangrene had been given. The records showed this advice was not recorded however we were told patients had been given this advice but not recorded in records. The practice told us they would check and code all the records.
- There were 0 patients with a potential missed diagnosis of diabetes.
- There were 13 patients with a potential missed diagnosis of chronic kidney disease stage 3, 4 or 5. Of the 5 patients we looked at, 3 had a missed diagnosis.
- The search of patients prescribed a gabapentinoid medicine found 25 of 142 patients had not had a review in the last 12 months of the 5 sets of records we reviewed 3 patients had received a review, 1 patient was having repeat prescriptions reduced to encourage contact with the practice and 1 patient had an appointment booked.
- The search of patients with asthma who had been prescribed 2 or more courses of rescue steroids with a review in a week of prescribing found 41 of 1108. Of the 5 sets of records we reviewed 4 patients had not been followed up within one week of the steroids being issued. We found 4 had been followed up in secondary care, and 1 patient had received a timely follow-up after their 1st course but outside the week for the second course.
- The search of patients with hypothyroidism that had not received a thyroid function test for 18 months found 1 patient out of 369 although the practice had requested the blood test this patient had complex needs and regularly cancelled appointments.

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

**The practice learned and made improvements when things went wrong and had a system to learn and make 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:	51
Number of events that required action:	51
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice recorded incidents in a dedicated system in a consistent and systematic manner.</li> <li>We saw incidents were discussed at staff meetings and learning delivered.</li> </ul>	

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

Event	Specific action taken
<u>Event</u> ECG electrode stock exhausted without re-ordering.  <u>Impact</u> Unable to carry out any ECGs	<u>Actions</u> Notify the deputy practice manager who ordered immediately using forms on the shared drive in the nursing folder.  <u>Learning</u> Protocol should be followed, and concerns raised if any issues occur. Clinical stock must be re-ordered using forms on the shared drive these to be completed each week and ordered from medical wholesalers by the deputy practice manager.
<u>Event</u> Staff not using sign in/out board, a fire safety risk even following numerous reminders.  <u>Impact</u> Unable to identify who is in the building for fire service.	<u>Actions</u> Reminder to all staff to use the portable board to sign in and out (in the entrance to the administration office).  <u>Learning</u> Administration to remind staff arriving and leaving.
<u>Event</u> Untidy room and dangerous lamp position left in a consultation room. The light was touching the couch and was red hot. There was also food utensils left in the room although food is not for consumption in clinical rooms. One staff member burnt their fingers trying to move this.  <u>Impact</u> Could have caused a fire, especially as this was lockdown afternoon, and no-one was using the room.	<u>Actions</u> Clean room and make it safe. Staff member who was burnt added their details to the Accident Book.  <u>Learning</u> Staff reminded to clean up and make rooms safe before leaving the consultation rooms.
<u>Event</u> The panic button in room 10 failed to work when a patient became unwell and collapsed.  <u>Impact</u> The staff member had to leave the patient to run down the corridor to seek assistance.	<u>Actions</u> Contact provider to have panic button fixed.  <u>Learning</u> Check panic button regularly in non-emergency situations.
<u>Event</u> Newly diagnosed diabetic delay in follow-up appointment patient's abnormal HbA1c reading was	<u>Actions</u>

<p>filed with a task sent to administrative team on December 2022. Patient queried as not heard about an appointment. Pre-diabetic, no urgency noted in task from clinician to administrative team and so booked in for routine appointment.</p> <p><u>Impact</u> Patient anxiety</p>	<p>Follow-up appointment booked for January 2023 with diabetes nurse.</p> <p><u>Learning</u> Inform patients of urgency so as not to cause anxiety.</p>
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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>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice had an effective system to manage patient safety alerts.</li> <li>• We saw alerts were shared appropriately at practice with the relevant staff members. Alerts were discussed in team meetings.</li> <li>• Records of recent alerts were available to view, with the actions that had been undertaken on the patients records that were affected by them.</li> </ul>	



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

**Effective needs assessment, care and treatment**

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients’ immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients’ treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients’ needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice had produced a standardised approach to follow up patients with symptoms that could indicate a serious illness.</li> <li>• Long term condition management recalls were seen during the remote clinical searches of the patients records to review and update medication and treatment.</li> <li>• The practice had embedded the use of software templates to ensure consistency of patient care and treatment coding.</li> </ul>	

**Effective care for the practice population**

Findings
<ul style="list-style-type: none"> <li>• The patients that were identified by the practice received a full assessment of their physical, mental and social needs.</li> <li>• Health checks, including frailty assessments, were offered to patients over 75 years of age.</li> <li>• Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.</li> </ul>

- 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. They had offered 1638 health checks for those that wanted one in the last 12 months and had completed 490 of these. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All 100 patients with a learning disability were offered an annual health check and 81 for those that wanted a check had received one in the last 12 months.
- 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**
- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
  - Staff who were responsible for reviews of patients with long-term conditions had received specific training.
  - GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
  - GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
  - The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
  - Adults with newly diagnosed cardio-vascular disease were offered statins.
  - Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	112	115	97.4%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	97	104	93.3%	Met 90% minimum

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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	97	104	93.3%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	97	104	93.3%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	110	114	96.5%	Met 95% WHO based target

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>

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	63.2%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	73.8%	N/A	70.3%	N/A
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). (3/31/2023 to 3/31/2023) (UKHSA)	77.1%	N/A	80.0%	Below 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	55.0%	61.9%	54.9%	No statistical variation

Any additional evidence or comments
Although the cervical screening target had improved since the last inspection, we asked the practice how they were working towards the England average target. We were told they were offering more flexible appointments and not just clinics at set times to ensure they were more accessible.

**Monitoring care and treatment**

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>The practice provided us with their program of audits and quality improvements that included the following audits and monitoring reports run on a regularly over the last 12 months.</p> <ul style="list-style-type: none"> <li>• Asthma and Allergic Rhinitis Audit</li> <li>• Infection PC audit</li> <li>• DOAC Audit</li> <li>• Safeguarding Audit</li> <li>• Entresto safety audit</li> <li>• Macrolides audit</li> <li>• Phenoxyethylpenicillin audit</li> <li>• Amoxicillin audit</li> <li>• Specimen folder audit - 1<sup>st</sup> cycle</li> <li>• Opioids Aware Audit</li> <li>• Specimen folder audit – 2<sup>nd</sup> cycle</li> <li>• Entresto safety audit</li> <li>• Specimen folder audit – 3<sup>rd</sup> cycle</li> <li>• Prednisolone, asthma Audit</li> <li>• CKD audit</li> <li>• Cold Chain / Vaccine Storage Audit</li> <li>• Coil / Implant Audit for Provide Sexual Health</li> <li>• Duty of care waste audit</li> <li>• A&amp;E/Urgent Treatment Centre Attendances</li> <li>• Telephone Contact Audit</li> <li>• NHS Health Check Audit</li> <li>• Lipid Management</li> <li>• Clopidogrel and Proton Pump Inhibitor</li> <li>• Handwashing audit</li> <li>• Data Security &amp; Protection Toolkit System Audit</li> </ul>	
<b>Any additional evidence or comments</b>	
<ul style="list-style-type: none"> <li>• The asthma and allergic rhinitis audit identified changes to procedures and treatment to improve care. The follow-up audit carried out six months later showed they had embedded the changes at the practice.</li> <li>• The repeated specimen folder audit identified a number of procedural processes that were needed to confirm that all staff were following these procedures to ensure specimens were not delayed or missed.</li> </ul>	

**Effective staffing**

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The lead GP trained GP registrars at the practice. Registrars are fully qualified doctors and are registered on the General Medical Council (GMC) list, they carry out a further three years of training experience at a training practice to qualify as a GP. The practice had four GP registrars working at the practice on the day we inspected. The lead GP explained the daily process to supervise the GP registrars.</li> </ul>	

**Coordinating care and treatment**

**Staff worked together 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>End of life care was discussed with the palliative care teams at regular multidisciplinary meetings. The practice provided evidence of meeting minutes. These showed consistent involvement with different teams to plan and deliver patient care and treatment with other organisations.</li> </ul>	

**Helping patients to live healthier lives**

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Patients had access to appropriate health assessments and NHS checks for patients aged 40 to 74. We saw 490 health checks had been provided for those that wanted one in the last 12 months. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.</li> </ul>	

**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 Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<p>Explanation of any answers and additional evidence</p> <ul style="list-style-type: none"> <li>The GP Clinicians told us how they recorded patient consent and DNACPR decision-making processes during interview and we saw how they were documented when we reviewed patient records. To ensure consent had been recorded appropriately and consistently the practice regularly monitored this process.</li> <li>The practice new patient information form offered guidance on online services access for patients. This guidance was available on the practice website.</li> </ul>	

## Caring

**Rating: Good**

At our last inspection we rated this practice as inadequate for providing effective care because:

- There were still many of the national GP survey indicators published in July 2021 that were significantly below local and national averages. However, all previously low patient satisfaction questions seen had improved.
- The practice had carried out their own patient satisfaction survey to understand why the 2020 and 2021 GP survey patient experience was so significantly lower than previous years.
- The practice had an action plan to improve patient satisfaction.
- Evidence of information to inform patients how to access and to protect online information.
- The practice had developed an information sharing protocol.

At this inspection we rated caring as Good because:

- All the national GP survey indicators published in July 2023 had improved and were now better than local and national averages.

### 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
Patients we spoke with during the inspection	We spoke with 7 patients on-site during the inspection. All patients were extremely positive about the access to the practice. They spoke positively about their care and treatment, and the review processes, to monitor their long-term health conditions. These patients also told us how helpful and supportive the reception and administrative staff were.

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 30/04/2023)	93.8%	86.0%	85.0%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2023 to 30/04/2023)	87.5%	84.7%	83.8%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP	96.3%	93.1%	93.0%	No statistical variation



appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2023 to 30/04/2023)				
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	78.6%	72.2%	71.3%	No statistical variation

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

Any additional evidence or comments
The patient participation group (PPG) supported the practice to understand patient views and satisfaction by carrying out a survey. They used the results to make changes and improvements which showed in the more positive responses over the last 2 years in the national GP survey results.

**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 on request.	

**National GP Patient Survey results**

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2023 to 30/04/2023)	96.6%	91.2%	90.3%	Tending towards variation (positive)

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y

Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Staff at the practice had access to a translation service to support patients whose first language was not English.</li> <li>• Paper information leaflets were readily available for people in the practice waiting room area. There was also a range of information available on the practice website.</li> </ul>	

Carers	Narrative
Percentage and number of carers identified.	<ul style="list-style-type: none"> <li>• The practice had identified 136 carer's which equates to 1.4% of the practice population.</li> </ul>
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> <li>• The practice social prescriber assisted the identification of carers and signposted them to supporting organisations.</li> <li>• We were told they had recently identified 1 young carer and were supporting their needs.</li> </ul>
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> <li>• The practice provided support to patients on an individual basis, and this included a with sympathy card.</li> <li>• Patients were signposted to bereavement support services available locally.</li> </ul>

### Privacy and dignity

**The practice respected patients' privacy and dignity.**

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• We saw appropriate signage at the reception desk to guide patients if they needed to speak confidentially in a private space.</li> </ul>	

## Responsive

**Rating: Good**

At our last inspection we rated this practice as requires improvement for providing responsive care because:

- There were still many of the national survey indicators published in July 2021 that were significantly below local and national averages. However, all previously low patient satisfaction questions seen had improved.
- The practice had carried out their own patient satisfaction survey to understand why the 2020 and 2021 GP survey patient experience was so significantly lower than previous years. The practice had developed an action plan to improve patient satisfaction.

At this inspection we rated the practice as good for providing responsive care because:

- All the national GP survey indicators published in July 2023 had improved and were now better than local and national averages.
- The changes made in the action plan had ensured more positive responses over the last 2 years in the national GP survey results.

### Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice had worked with the other members of their primary care network to provide services that reflected the local population needs.</li> </ul>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am - 6:30pm
Tuesday	8am - 6:30pm
Wednesday	8am - 6:30pm
Thursday	8am - 6:30pm
Friday	8am - 6:30pm
Bookable appointments were held outside the practice's core operating hours at the practice and at the other practices within their primary care network (PCN) practices by a range of clinicians.	

Monday	6:30pm - 8pm
Tuesday	6:30pm - 8pm
Wednesday	6:30pm - 8pm
Thursday	6:30pm - 8pm
Friday	6:30pm - 8pm
Saturday	9am – 5pm

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

- Patients had a named GP who supported them in any setting they lived.
- The practice responded to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GPs would respond quickly, to enable prompt burial.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical and life limiting issues.
- Appointments were available outside school hours for children so that they did not need to miss school to attend the practice.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Pre-bookable appointments outside core practice appointment times were also available to all patients at additional locations within the area, as the practice was a member of primary care network this included appointments on Saturday and Sunday.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were able to register with the practice, including those with no fixed abode such as homeless people and Travelers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability

#### Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (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

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023)	63.4%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	65.3%	55.5%	54.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	62.8%	54.5%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	78.5%	75.9%	72.0%	No statistical variation

Source	Feedback
NHS.uk website (formerly NHS Choices)	There were 5 reviews left over the last 2 years. Three were 5 star reviews, one was a 4 star review and there was a 1 star review. The practice had left a response to every review.

### Listening and learning from concerns and complaints

**Complaints were listened and responded to and used to improve the quality.**

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

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

Example(s) of learning from complaints.

Complaint	Specific action taken
<p><u>Complaint</u> Patient unhappy had to pay for private insurance form to be completed at the practice.</p> <p><u>Impact</u> Patient expectation not met.</p>	<p><u>Actions</u> Explained cost to patient.</p> <p><u>Learning</u> When accepting a form to be completed staff must explain there is a cost.</p>
<p><u>Complaint</u> Request for an apology following an appointment where the patient felt not listened to.</p> <p><u>Impact</u> Patient expectation not met.</p>	<p><u>Actions</u> Explanation and apology sent to patient.</p> <p><u>Learning</u> Provide patients explanation if unable to deliver their request.</p>
<p><u>Complaint</u> Patient complained saw 2 different GPs and got two different 2 opinions.</p> <p><u>Impact</u> Patient feels got conflicting information.</p>	<p><u>Actions</u> Follow-up appointment arranged with follow-up care.</p> <p><u>Learning</u> Clinical staff to review previous consultations for information provided previously.</p>
<p><u>Complaint</u> Patient unhappy with the information provided about relatives end of life care.</p> <p><u>Impact</u> Patient expectation not met.</p>	<p><u>Actions</u> Follow-up care provided.</p> <p><u>Learning</u> Staff to confirm patients have the information they need.</p>

**Well-led**

**Rating: Good**

**Leadership capacity and capability**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	

- The practice worked with their primary care network (PCN) practices to understand the challenges of the local population. An example of this was the rapid increase of new houses in developments within the practice catchment area.

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

#### **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: <ul style="list-style-type: none"> <li>• Staff we spoke with told us that the practice vision and values were discussed in team meetings.</li> <li>• We were provided evidence of actions against an on-going development plan that monitored improvements.</li> </ul>	

#### **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: <ul style="list-style-type: none"> <li>• The we policies and procedures we reviewed had all been updated to meet local and national guidance.</li> </ul>	

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

Source	Feedback
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Staff on site	<ul style="list-style-type: none"> <li>The 11 staff members we spoke with were positive about working at the practice, and confirmed they felt able to raise issues and concerns with the knowledge they would be supported to do so.</li> <li>Recently employed staff members told us they felt supported with the induction programme provided.</li> </ul>
Staff feedback forms	<ul style="list-style-type: none"> <li>All comments were positive about the support from the management team. Staff members that also worked at other practices, told us Tollgate Health Centre was a good practice to work.</li> </ul>

#### Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
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.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>We found the improvements that had been made over the last 2 years ensured the governance arrangements had been effectively embedded and regularly reviewed.</li> </ul>	

#### Managing risks, issues and performance

**The practice had clear and effective processes for managing risks, issues and performance.**

	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.	Y
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:	

- Effective risk management systems had been established and embedded. This included an audit process to monitor service performance run on a monthly basis.

#### 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice monitored patient data using a suite of reports that monitored long term condition management.</li> <li>• Management staff had received training and understood the responsibility to make statutory notifications to the care quality commission.</li> </ul>	

#### 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
Explanation of any answers and additional evidence <ul style="list-style-type: none"> <li>• When we reviewed patient records, we saw evidence that patients' consent was obtained, and appropriate interactions were recorded.</li> <li>• The practice website informed patients how their records were stored, managed, and provided the information sharing protocol for online services.</li> </ul>	

**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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice carried out their own regular patient satisfaction surveys.</li> <li>• We saw staff involvement in the planning and delivery of services reflected in the practice meeting minutes.</li> <li>• The patient participation group information was available on the practice website. Notes from the meetings were also available to view.</li> </ul>	

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> <li>• We spoke with 3 members of the patient participation group (PPG) who told us they had regular meetings with the practice leadership team.</li> <li>• Members we spoke with were positive in their feedback about the practice commitment to collaborate with them, to listen to their feedback.</li> </ul>

**Continuous improvement and innovation**

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice demonstrated that the improvements made over the last two years had changed the culture at the practice.</li> <li>• Staff gave examples of learning from events, complaints and staff experience had been used to create a safer, more open environment for staff and patients.</li> <li>• The quality improvement work such as audits and reports had a positive effect on supporting the staff to deliver safe and effective care to their patients.</li> </ul>	

**Examples of continuous learning and improvement**

The practice provided us with their program of audits and quality improvements including monthly monitoring. <ul style="list-style-type: none"> <li>• Asthma and Allergic Rhinitis Audit</li> <li>• Infection PC audit</li> <li>• DOAC Audit</li> </ul>
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- Safeguarding Audit
- Entresto safety audit
- Macrolides audit
- Phenoxymethylpenicillin audit
- Amoxicillin audit
- Specimen folder audit - 1<sup>st</sup> cycle
- Opioids Aware Audit
- Specimen folder audit – 2<sup>nd</sup> cycle
- Entresto safety audit
- Specimen folder audit – 3<sup>rd</sup> cycle
- Prednisolone, asthma Audit
- CKD audit
- Cold Chain / Vaccine Storage Audit
- Coil / Implant Audit for Provide Sexual Health
- Duty of care waste audit
- A&E/Urgent Treatment Centre Attendances
- Telephone Contact Audit
- NHS Health Check Audit
- Lipid Management
- Clopidogrel and Proton Pump Inhibitor
- Handwashing audit
- Data Security & Protection Toolkit System Audit

**Notes: CQC GP Insight**

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

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

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

The following language is used for showing variation:

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

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

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

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

#### **Glossary of terms used in the data.**

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **UKHSA:** UK Health and Security Agency.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ‰ = per thousand.