Care Quality Commission

Inspection Evidence Table

Perry Park Surgery (1-548120282)

Inspection date: 16 September 2019

Date of data download: 06 September 2019

Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Effective Rating: Good

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 used digital services securely and effectively and conformed to relevant digital and information security standards.	Y

Explanation of any answers and additional evidence:

- The practice made use of templates integrated in the clinical system for the management of long-term conditions to help ensure consistent care and treatment.
- Staff were able to access various guidelines via their computers such as the National Institute for Health and Care Excellence (NICE) guidelines.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHSBSA)	0.75	0.75	0.75	No statistical variation

Older people Population group rating: Good

Findings
• The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.

- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- We noted a higher exception reporting for patients who were bone protection medicine. The practice explained that this was due to following the NICE guidance of having a five-year treatment holiday from the medicine.

People with long-term conditions Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	82.1%	80.1%	78.8%	No statistical variation
Exception rate (number of exceptions).	11.5% (45)	12.5%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	81.9%	77.2%	77.7%	No statistical variation
Exception rate (number of exceptions).	8.2% (32)	10.4%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	81.9%	81.3%	80.1%	No statistical variation
Exception rate (number of exceptions).	15.6% (61)	11.4%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	77.0%	76.6%	76.0%	No statistical variation
Exception rate (number of exceptions).	2.2% (7)	6.3%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	86.6%	91.4%	89.7%	No statistical variation
Exception rate (number of exceptions).	7.3% (10)	11.2%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	84.3%	83.1%	82.6%	No statistical variation
Exception rate (number of exceptions).	2.9% (27)	4.5%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	89.4%	88.7%	90.0%	No statistical variation
Exception rate (number of exceptions).	4.3% (3)	8.2%	6.7%	N/A

Families, children and young people Population group rating: Good

Findings

- The service had acted to improve childhood immunisation uptake rates although it was aware that more action was required.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	49	58	84.5%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	60	64	93.8%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	60	64	93.8%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	60	64	93.8%	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

Although the above data table above shows the practice achievement for vaccination for children aged one was below the 90% target, the practice had demonstrated an improvement in comparison to the previous year's data.

To achieve improvement the practice had taken part in a childhood immunisation pilot organised by the CCG. As a result, the practice amended the processes for monitoring and following up non-attenders which had improved achievement. An administration staff member had been appointed as a dedicated lead to review practice performance such as those related to QOF and childhood immunisation targets.

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

- The practices achievement for cervical cytology was 67% and was below the 70% uptake level.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	66.8%	N/A	N/A	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	66.2%	63.8%	69.9%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	49.0%	44.0%	54.4%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	93.1%	74.2%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	44.0%	52.1%	51.9%	No statistical variation

Any additional evidence or comments

The practice had a standard recall procedure to engage with non-responders. The site lead was responsible for recalling patients on the phone and then sent out letters. However, the service had recognised this as a limitation because it was reliant on one person. The practice was in the process of training other staff on the patient record system so that they could identify non-responders and engage them where relevant. The practice hoped that this would improve data.

Furthermore, the lead administration staff whose role was to oversee practice performance was unable to fully perform the role due to shortage in administration staff. A reception staff member was due to finish the training which would allow the lead administration staff to perform their intended role of overseeing practice performance including cervical cytology. The practice hoped that this would have a positive impact on achievement for cervical cytology.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- 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.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	96.1%	93.3%	89.5%	No statistical variation
Exception rate (number of exceptions).	10.5% (6)	9.5%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	98.0%	93.4%	90.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	10.5% (6)	7.8%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	85.2%	85.9%	83.0%	No statistical variation
Exception rate (number of exceptions).	3.6% (1)	6.0%	6.6%	N/A

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.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	556.7	546.1	537.5
Overall QOF score (as a percentage of maximum)	99.6%	97.7%	96.2%
Overall QOF exception reporting (all domains)	5.0%	6.1%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y
Quality improvement activity was targeted at the areas where there were concerns.	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

The practice had carried out several audits including atrial fibrillation, antibiotic prescribing, antipsychotic prescribing, on quality of referral letters, minor surgery and audits to review if pharmacies were passing on relevant sections from the prescription.

We looked at the minor surgery audit that had been carried out annually since 2015. We looked at the 2017 and 2018 audit which reviewed quality of recordkeeping; including recording of operator, consent and the site of the procedure. The 2017 audit reviewed 32 records and the 2018 audit reviewed 29 records and all showed a compliance 100% to standards. The second part of the audit reviewed samples sent to the lab for testing and if results were received and documented with any malignancy identified and if there were any post-operative complications. The audit identified 100% compliance.

We looked at an antibiotic audit carried out with the assistance of the CCG medicines management team which identified some improvements. A re-audit in November 2018 was carried out which demonstrated improvement.

The practice planned to carry out a discharge letter audit to review if all actions had been completed as per the discharge letter. This was a single cycle audit and a re-audit was planned for the next month.

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. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	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
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	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:

- The practice was supportive of staff in developing the skills needed to deliver the service. For example, the practice had ensured staff were trained in various administration processes to ensure flexibility.
- Staff had access to a range of online training and were given time to complete this.
- New staff had access to induction training. We reviewed the staff records for the most recently recruited Health Care Assistant and saw that they had completed the care certificate.
- The service was supported by two part time nurses and the provider was aware that additional nursing hours would provide greater flexibility and to offer service such as those related to cervical cytology.

Coordinating care and treatment

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

Indicator	Y/N/Partial

The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
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
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y

Explanation of any answers and additional evidence:

- The practice participated in regular multi-disciplinary team meetings with the community healthcare and palliative care teams, to discuss the practices most vulnerable patients.

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, tackling obesity.	Y
Explanation of any answers and additional evidence: • The practice offered new patient and NHS Health Checks and followed up where actions were needed. • The practice offered some inhouse services such as smoking cessation. They also referred or signposted patients to other local services to support their health and wellbeing. • There was a range of health information and signposting to support groups available in the waiting area.	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	98.9%	96.1%	95.1%	Variation (positive)
Exception rate (number of exceptions).	0.3% (4)	0.6%	0.8%	N/A

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
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y
Explanation of any answers and additional evidence: • We looked at a minor surgery audit which showed that consent was being sought before the procedure.	

Well-led Rating: Good

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	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 current leadership were aware of the challenges to the quality and sustainability of the service. The lead GP was planning to retire within the next six months and had taken on new partners as part of the succession planning.

We were told that the new GP partners were exploring options on the long-term sustainability of the service including options to join/merge with other larger organisations. However, this was currently being explored and no definite plans had been made.

Vision and strategy

The practice was in a process of transition and the new partners were considering various options for the practice going forward. A formal strategy had yet to be developed and communicated to all staff to ensure provision of high-quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
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:

The practice had a vision and value in place and most staff were able to articulate this. However, the practice was in a process of transition with the two founding partners due to retire within the next six months. The new partners were exploring options to ensure sustainability of the service going forward

and a formal strategy yet to be developed and communicated to all staff members.

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's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	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:

Staff members we spoke with told us that there had been a significant change in the culture of the service which has resulted in a positive working environment.

Previously the practice had merged with Kingsdale Surgery which was now a branch site. However, both sites continued to work separately with separate systems and processes. Generally, staff members worked separately with limited integration.

We were told that this had been addressed over the last couple of years with greater integration of systems and staff. For example, a new telephone system had been installed allowing calls to be answered at either site. Previously, patients were only able to book appointments at the site they had initially registered. However, with greater integration of the appointment system patients were now able to book an appointment at either site. This was supported by the patient group (PPG) as patients could choose the site that offered quicker appointment availability.

Staff were offered training on all relevant systems and the staffing structure had been reviewed so that they worked at both sites providing greater flexibility and resilience a times of unplanned absence.

To integrate staff from sites and to ensure they worked well as a team, we were told that twice yearly team building exercise were organised. Staff members we spoke with confirmed the positive change in the culture of the service. Staff felt there was a better working environment, and this enabled them to offer improved service to patients.

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

Source	Feedback
Staff	Staff members we spoke with were positive about their experience of working at the practice. They told us there had been a change in the working practices over the last couple of years and this resulted in a better working environment. Systems and processes had been improved to ingrate the main site with the branch site allowing them to offer improved service to patients.

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

Explanation of any answers and additional evidence:

The practice manager told us that they had started working at the practice for the last two years. They did not have a background in primary care and told us that their responsibility was to have an oversight of systems and processes such as staffing. The lead GP had the responsibility along with an administration staff for the oversight of performance such as those related to patient outcomes (QOF). The practice manager was now receiving support from the CCG and the lead GP to help them understand the clinical systems and were taking part in meetings to review performance on patient outcomes with the GP to enable them to take lead eventually.

Managing risks, issues and performance

The practice had identified risks related to the change in GP partnership and was working to mitigate these.

	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 systematic programme of clinical and internal audit.	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: Two of the partners were due to retire and two new GP partners had joined the practice. The lead GP was due to retire within the next six months and whilst we were told that the new partners had a plan to ensure a smooth transition this had not been formalised and communicated to all staff. The practice recognised this as a potential risk and was working with the new partners to manage and mitigate where relevant.	

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 adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: From our discussion with staff and management it was clear that performance information was used to hold staff to account. There was an effective system to identify risks and systems and processes had been developed to minimise risks and deliver a quality service.	

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: There was a branch site (Kingsdale Surgery) and patients previously could only book an appointment at the site they had initially registered. We were told that patients found this frustrating particularly if they were able to book an appointment sooner at the other site. The PPG were keen to see patients being able to book appointments at either site. Following installation of a new telephone system which integrated both sites, patients were able to book appointments at either site.	

Feedback from Patients

Feedback
We received 33 CQC comment cards and all were positive about the service staff and the quality of care received.

Continuous improvement and innovation

There were 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:	

Examples of continuous learning and improvement
• The practice took part in the QOF pilot to determine future priorities and was one of 36 practices taking part nationally.

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.
- 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.

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

Glossary of terms used in the data.

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