Care Quality Commission

Inspection Evidence Table

Kingsbury Health and Wellbeing (1-2218583661)

Inspection date: 10th December 2019

Date of data download: 09 December 2019

Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

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 provider could demonstrate that all staff used and referred to national guidance when undertaking patient care. Patient records were observed to support this. • The lead GP and the clinical pharmacist met every two weeks to monitor patient treatment. • The provider could demonstrate a system of how they managed unplanned admissions and re-	

admissions to secondary care.

- We saw examples of relevant digital and information security standards. For example, we saw evidence of the General Data Protection Regulation (GDPR) guidelines being implemented.

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) (01/10/2018 to 30/09/2019) (NHSBSA)	0.15	0.40	0.74	Significant Variation (positive)

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 discharge summaries were individually checked by the lead GP and action taken if applicable.
- 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 and were led by the nursing team.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice looked after 18 patients at a local nursing home through a relationship with the local care home team.

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.
- 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. The practice had recently carried out an atrial fibrillation audit.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring on the practice premises.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately. This was conducted in the practice and a referral made to secondary care services if required.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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 (01/04/2018 to 31/03/2019) (QOF)	84.4%	76.4%	79.3%	No statistical variation
Exception rate (number of exceptions).	8.0% (52)	10.8%	12.8%	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 (01/04/2018 to 31/03/2019) (QOF)	90.0%	78.6%	78.1%	Variation (positive)
Exception rate (number of exceptions).	2.9% (19)	7.6%	9.4%	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 (01/04/2018 to 31/03/2019) (QOF)	87.1%	80.8%	81.3%	No statistical variation
Exception rate (number of exceptions).	6.8% (44)	7.9%	12.7%	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 (01/04/2018 to 31/03/2019) (QOF)	93.0%	78.0%	75.9%	Significant Variation (positive)
Exception rate (number of exceptions).	0.4% (1)	2.5%	7.4%	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 (01/04/2018 to 31/03/2019) (QOF)	98.0%	92.6%	89.6%	Tending towards variation (positive)
Exception rate (number of exceptions).	5.8% (3)	6.9%	11.2%	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 (01/04/2018 to 31/03/2019) (QOF)	92.5%	82.2%	83.0%	Significant Variation (positive)
Exception rate (number of exceptions).	1.6% (16)	3.9%	4.0%	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 (01/04/2018 to 31/03/2019) (QOF)	98.1%	86.5%	91.1%	Tending towards variation (positive)
Exception rate (number of exceptions).	16.1% (10)	9.1%	5.9%	N/A

Families, children and young people Population group rating: Good

Findings

- The practice has met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for one of four childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations. The practice was able to demonstrate a system of how this was managed.
- 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. Services could be accessed both at the practice and through local services.
- 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)	48	49	98.0%	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) (01/04/2018 to 31/03/2019) (NHS England)	54	64	84.4%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	54	64	84.4%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	53	64	82.8%	Below 90% minimum

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

Any additional evidence or comments
• During our inspection, the practice was able to provide unverified evidence that they were on track to meet all childhood immunisation minimum standards for the upcoming year.

Working age people (including those recently retired and students)

Population group rating: Good

Findings
• The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. The practice conducted a search of their electronic patient records for eligible patients. • 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	England	England

		average	average	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)	76.3%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	83.0%	61.8%	72.1%	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)	58.7%	42.0%	57.3%	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)	100.0%	79.2%	69.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	46.2%	53.8%	53.8%	No statistical variation

Any additional evidence or comments

- The practice had during the inspection, we observed the processes in place to track urgent referrals for suspected cancer.
- The practice had identified cervical screening uptake as an area for improvement. Actions taken included identifying access as a barrier to uptake in younger age-groups. The practice now offered a Saturday screening clinic at the practice and access to evening and weekend screening appointments at the local primary care hub services.

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. The practice had a learning disability register which held 15 patients. All of these patients had their annual health check.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. The practice used the recognised Co-ordinate My Care system to share key information about these patients and their preferences with other agencies (for example, the ambulance service). The practice had recently conducted an audit of its end of life care.
- 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 referred to local drug and alcohol rehabilitation centres.

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. The practice would refer to a memory clinic in the first instance.
- 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 (01/04/2018 to 31/03/2019) (QOF)	98.1%	90.3%	89.4%	Tending towards variation (positive)
Exception rate (number of exceptions).	5.5% (3)	6.6%	12.3%	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 (01/04/2018 to 31/03/2019) (QOF)	100.0%	91.1%	90.2%	Variation (positive)
Exception rate (number of exceptions).	5.5% (3)	5.8%	10.1%	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 (01/04/2018 to 31/03/2019) (QOF)	91.7%	84.6%	83.6%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	3.5%	6.7%	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)	559	No Data	539.2
Overall QOF score (as a percentage of maximum)	100%	No Data	96.4%
Overall QOF exception reporting (all domains)	4.6%	No Data	No Data

	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

Any additional evidence or comments

- During our inspection, we reviewed a two-cycle audit into atrial fibrillation. Searches were run using the practice's electronic system to see all active patients with the condition. The aim of the audit was to ensure all patients diagnosed were on active anti-coagulant treatment or offered this as a treatment. The audit was run from 2018-2019 where 73 patients were found and subsequently re-run recently for 2019-2020 where 79 patients were found. Through these searches, the practice had improved both their identification methods and their treatment efficiency.
- A two-cycle audit was completed on osteoporosis prompted by a hospital service query. The audit took place over four phases and focused on the practice's osteoporosis register. The audit resulted in 63 patients being reviewed in January 2018. Of these patients, several were referred on to secondary care for further investigation. The second cycle was conducted in June 2019 and resulted in the practice developing of patient record alerts associated with osteoporosis medication and ongoing investigations. The practice intends to continue the register and initiate reviews every six months.
- A single cycle audit was performed in November 2019 reviewing recorded deaths in a 12-month period. The audit looked at demographics, underlying conditions, cause of death, as well as practice performance in comparison to palliative care key performance indicators. Learning points were identified in several cases to inform future clinical practice.

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: • We looked at five staff records and found that staff training was suitable for their job roles. While the information was provided, there was some difficulty in locating some of this information during our inspection visit. We expressed that the system for monitoring staff training should be reviewed.	

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 (01/04/2018 to 31/03/2019) (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 had practice had an attached care-coordinator who was able to signpost patients to a range of local services and resources.	

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 used Co-ordinate My Care, a service associated with advanced care planning for patients in the last 12 months of their lives during our inspection. The practice had six patients on the register and intended to build upon this following the results of their end of life audit. • The practice had a carer register of 292 of their patient population. This was 6% of their patient population.	

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 (01/04/2018 to 31/03/2019) (QOF)	98.1%	95.6%	95.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	0.2% (3)	0.5%	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: • During our inspection, we saw evidence that the practice had procedures in place to obtain informed written consent from patients for riskier procedures such as ear syringing.	

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.	N

Explanation of any answers and additional evidence:

- During the inspection, we established that the provider was operating single handed due to difficulties recruiting a second GP partner. This had been managed using long-term locum GPs.
- We also found that the practice had staff concerns which were being addressed. The practice had carried out a comprehensive risk assessment which reviewed the issues and challenges potentially being faced.

Vision and strategy

The practice had a clear vision and credible strategy to provide 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.	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:

- The practice had a clear mission statement which focused on accessibility of services.
- Staff we spoke with on the day showed an understanding of the practice vision.
- The practice took opportunities to provide enhanced primary care services (that is primary care services over and above those specified in the national GP contract) for the benefit of the local population.

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: • The practice had formal mechanisms encouraging staff feedback such as regular staff meetings. • Both clinical and administrative staff we spoke with said they were supported and comfortable to raise issues if they felt they needed to. • We encouraged following the inspection that further methods should be considered to allow for staff to give their feedback to the management of the service.	

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

Source	Feedback
Staff	Well supported by the management especially the GP Lead for the practice. Staff feel they are looked after and that an open-door policy is in place for any concerns to be raised.

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:	

- During the inspection, we observed a system which allocated specific roles and responsibilities to members of staff for that day. This was written down and available to reference throughout the day and required ticking or marking for specific tasks once completed.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	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:

- The practice had a clear system for outlining risks and took effective action when risks were identified. For example, the mislabelling of a blood sample was identified as a significant event and was followed up by implementing additional checks before samples were dispatched for analysis.
- During the inspection, we found that staff training records were up to date.

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:

- We saw that where data was seen to be below expected levels, action plans were implemented to address and improve these figures. The practice used validated data from reliable sources which included the primary care network, clinical commissioning group and patient surveys such as the National GP Patient Survey.

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:

- During the inspection, we observed good communication with the Patient Participation Group including full minutes of a meeting detailing concerns being discussed.
- The practice was able to demonstrate the use of a complaints log and actions they took as a result during the inspection.
- We were unable to find any evidence of the practice conducting their own independent survey of patient views separate from the Patient participation group.

Feedback from Patient Participation Group.

Feedback
• The practice implemented a display board around two years ago at the group's request. • The group meet twice annually where clinical staff are present. The group would like to meet more often if possible. • Positive experiences were identified from the group regarding the telephone accessibility of the practice and online services including repeat prescriptions services.

Any additional evidence
• The group compose a newsletter which is available online and produced every three months. • The group discussed the availability of appointments with us. They said that same day advice given by clinicians aided their queries effectively.

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:

- The practice had identified diabetes as a clinical priority. They had set up a pre-diabetes register

made up of 600 patients from their patient population and promoted the NHS diabetes prevention programme to these patients while coding them as high risk to alert clinicians.

Examples of continuous learning and improvement

- In 2017, the practice took part in research focusing on type II diabetes in south east Asian populations.

- In 2018, the practice took part in a mobile phone app development scheme to improve diabetes control. This was conducted across North West London for patients who could not attend face to face diabetic support schemes. The practice was able to demonstrate that 50% of these patients experienced an improvement in diabetic control following participation in the scheme.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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