

Care Quality Commission

Inspection Evidence Table

Kirkley Mill Surgery (1-4436780475)

Inspection date: 23 August 2018

Date of data download: 08 August 2018

Please note: Any Quality Outcomes Framework (QOF) data relates to 2016/17.

Safe

Safety systems and processes

| Safeguarding | Y/N |
|---|-------|
| There was a lead member(s) of staff for safeguarding processes and procedures. | Yes |
| Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Yes |
| Policies were in place covering adult and child safeguarding. | Yes |
| Policies were updated and reviewed and accessible to all staff. | Yes |
| Partners and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs). | Yes |
| Information about patients at risk was shared with other agencies in a timely way. | Yes |
| Systems were in place to highlight vulnerable patients on record. There was a risk register of specific patients. | Yes |
| Disclosure and Barring Service checks were undertaken where required. | Yes * |
| Explanation of any 'No' answers: *One member of clinical staff did not have a Disclosure and Barring Service (DBS) check completed. The practice was aware of this and had recently applied for one. There was no risk assessment in place whilst this was being awaited. Following our inspection, evidence of a DBS check for this member of staff was provided. | |

| Recruitment Systems | Y/N |
|--|-----|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Yes |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role. | Yes |
| Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | Yes |
| Staff who require medical indemnity insurance had it in place. | Yes |

| Safety Records | Y/N |
|---|-----|
| There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/Test: 20/06/2018. | Yes |
| There was a record of equipment calibration. Date of last calibration: 20/06/2018. | Yes |
| Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals. | Yes |
| Fire procedure in place. | Yes |
| Fire extinguisher checks. | Yes |
| Fire drills and logs. | Yes |
| Fire alarm checks. | Yes |
| Fire training for staff. | Yes |
| Fire marshals. | Yes |
| Fire risk assessment. Date of completion: 30/05/2018. | Yes |
| Actions were identified and completed. | Yes |
| Additional observations: The practice had two trained fire marshals and had identified that more fire marshals were needed. They were awaiting dates for training, so that all reception staff would be trained to undertake the fire marshal role. | |
| Health and safety Premises/security risk assessment? Date of last assessment: 28/08/2018. | No |
| Health and safety risk assessment and actions. Date of last assessment: 28/08/2018. | No |
| Additional comments: There was no health and safety or premises/security risk assessment. The practice completed and submitted these following the inspection. | |

| Infection control | Y/N |
|---|-----|
| Risk assessment and policy in place. | Yes |
| Date of last infection control audit: 11/01/18. The practice acted on any issues identified. Detail: Actions had been implemented following the infection control audit. Posters for the management of contamination injury were displayed. A specimen refrigerator was now in use. There was evidence of escalation of some issues, which remained incomplete, for example, the removal of the limescale on taps. The clinical waste area and bins were secured. | Yes |
| The arrangements for managing waste and clinical specimens kept people safe? | Yes |
| Explanation of any answers: Other infection prevention and control audits were undertaken and | |

identified actions were followed up. An environmental check was completed monthly and one of the completed actions included a pedal operated bin being replaced. Cleaning schedules were in place and we saw evidence of escalation, where spot checks had identified concern with the standard of the cleaning. The practice had established a contract with another cleaning company.

Any additional evidence
 All staff had completed infection prevention and control training.

Risks to patients

| Question | Y/N |
|--|------|
| There was an effective approach to managing staff absences and busy periods. | Yes |
| Comprehensive risk assessments were carried out for patients. | Yes |
| Risk management plans were developed in line with national guidance. | Yes |
| Staff knew how to respond to emergency situations. | Yes |
| 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. | Yes* |
| In addition, there was a process in the practice for urgent clinician review of such patients. | Yes* |
| The practice had equipment available to enable assessment of patients with presumed sepsis. | No |
| There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance. | No |
| Explanation of any answers: All clinical and non-clinical staff had completed basic life support and anaphylaxis training as appropriate to their role. Guidance was in place for responding to patients who presented with, for example, chest pain or possible stroke. Reception staff were aware of guidance for recognising the deteriorating patient, but specific guidance, for example for sepsis was not in place. The practice had an adult and child oximeter. There was no baby/infant oximeter. | |

Information to deliver safe care and treatment

| Question | Y/N |
|---|------|
| Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation. | Yes |
| Referral letters contained specific information to allow appropriate and timely referrals. | Yes |
| Referrals to specialist services were documented. | Yes |
| The practice had a documented approach to the management of test results and this was managed in a timely manner. | Yes |
| The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols. | Yes* |
| Explanation of any answers: All administration staff had received read code training and all staff received scanning and coding training in July 2018. The coding of patients had improved, however the practice recognised that this work was ongoing. We identified some patients with probable hypertension and patients on medicines for gout who had not been coded. Clinical staff told us that they handed over to the out of hours service, however, there was no evidence of this, by read coding of the contact or other documentation. An audit | |

of patients on oral anticoagulation therapy with no read code identified that of 131 patients on anticoagulation therapy, 102 had a coded diagnosis and 29 had no coded diagnosis.

Two additional staff were in place to undertake summarising and work was ongoing to reduce the number of patient records which needed to be summarised. We were advised that this work had been impacted by the number of new patient registrations. The practice had 1072 patients whose notes needed to be summarised.

Appropriate and safe use of medicines

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|---------------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2017 to 31/03/2018) NHS Business Service Authority - NHSBSA) | 0.98 | 1.05 | 0.95 | Comparable with other practices |
| The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2017 to 31/03/2018) (NHSBSA) | 7.9% | 7.9% | 8.8% | Comparable with other practices |

| Medicines Management | Y/N |
|---|------|
| 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. | Yes |
| Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions (PGDs) or Patient Specific Directions (PSDs)). | Yes* |
| Prescriptions (pads and computer prescription paper) were kept securely and monitored. | Yes |
| There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. | Yes |
| The practice monitored the prescribing of controlled drugs. (For example, audits for unusual prescribing, quantities, dose, formulations and strength). | Yes |
| Up to date local prescribing guidelines were in use. | Yes |
| Clinical staff were able to access a local microbiologist for advice. | Yes |
| The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held. | No* |
| The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases. | Yes |
| There was medical oxygen on site. | Yes |
| The practice had a defibrillator. | Yes |
| Both were checked regularly and this was recorded. | Yes |
| Medicines that required refrigeration were appropriately stored, monitored and | Yes* |

| |
|--|
| transported in line with PHE guidance to ensure they remained safe and effective in use. |
| <p>Explanation of any answers:</p> <p>The practice's most recent data on the number of antibacterial prescription items prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR PU) from March 2018 to May 2018 was 0.29.</p> <p>The practice's most recent data, from March 2018 to May 2018, on 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) was 9.2. The practice was aware of their prescribing data, were auditing and monitoring it. A two-cycle clinical audit undertaken in August 2018 showed a reduction in the prescribing of cephalosporin and quinolones, but an increase in their prescribing of co-amoxiclav, since November 2017. Actions had been identified which included, a clinical education session for a clinical meeting, a pop up alert to be added to alert clinicians and a copy of the CCG antibiotic formulary to be available in every clinical room, including the locum pack.</p> <p>We found two PGD's had not been authorised. Immediate action was undertaken to authorise these.</p> <p>We reviewed the stock of emergency medicines and found there was no benzylpenicillin (an antibiotic used to treat some bacterial infections), no naloxone (a medicine used to block the effects of opioids, especially in overdose) and no diclofenac (a medicine that reduces inflammation and pain). There was no risk assessment for this decision. The provider agreed to review this and complete a risk assessment as appropriate. Following the inspection, they advised that benzylpenicillin had been ordered.</p> <p>A recent infection prevention and control audit had identified the need to ensure that medicines that required refrigeration were transported at the correct temperature. Although the need to transport these medicines was rare, the practice was in the process of ensuring a system was in place.</p> <p>Effective protocols and processes were in place to monitor and review patients prescribed high risk medicines. We reviewed patients prescribed four high risk medicines and found appropriate monitoring and review was in place.</p> |

Track record on safety and lessons learned and improvements made

| Significant events | Y/N |
|---|--------------------------------|
| There was a system for recording and acting on significant events. | Yes* |
| Staff understood how to report incidents both internally and externally. | Yes |
| There was evidence of learning and dissemination of information. | Yes |
| Number of events recorded in last 12 months. | 50 (since November 2017) |
| Number of events that required action. | 26 (some no action identified) |
| Any additional evidence | |
| The Suffolk GP Federation had recently established an electronic system (Datix) to record all events. They were keen to ensure that they had oversight of all significant events from the practice and their other services and could review and monitor identified learning, as well as identify trends. Staff were aware of | |

how to report significant events using the new system. Incidents were reported and managed at a corporate level. Staff we spoke with were not all aware of the outcomes of significant events. The practice planned to discuss significant events more formally at the clinical and whole practice team meetings.

Before the inspection, we had been sent a spreadsheet of significant events, which showed that events were logged, responded to and lessons learnt. On the day of the inspection, managerial staff at the practice were not able to access the electronic system where significant events were logged and reviewed. The Director of Primary Care who had responsibility for significant events at the practice was not available on the day of the inspection and the Practice Services Director advised that the other manager dealt with this area. The Suffolk GP Federation advised that monthly reports were sent to the GP clinical lead for discussion in the monthly primary care review meetings and that they would send these reports to the managerial staff.

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

| Event | Specific action taken |
|--|--|
| Identified that people could see the reception area from outside when the practice is closed. | Blinds put up so that this area is not able to be seen from outside when the practice is closed. |
| Unauthorised access of patient's records. | Safeguarding patient privacy audits undertaken monthly, on random members of staff, on random days. No inappropriate access to patients' records identified. |
| Responding to violent, aggressive or threatening patient behaviour. Increase noted in August 2018. | Guidance reiterated on how to respond to patients and the process to follow after an incident occurs. Violent and aggressive patient policy was reviewed. An agreed warning letter was now available. To arrange a visit from a security specialist to review security. Conflict resolution training to be arranged. |

| Safety Alerts | Y/N |
|---|------|
| There was a system for recording and acting on safety alerts. | Yes* |
| Staff understand how to deal with alerts. | Yes |
| Comments on systems in place: Alerts were received and logged at a corporate level and shared with the practice. Relevant searches were undertaken by the practice, with clinical oversight as appropriate. However, we identified one alert from October 2017, which advised that patients on high dose gabapentin, who were also prescribed morphine and had coexisting chronic obstructive pulmonary disease should be reviewed and they had not been. This alert was before the provider took responsibility for the practice. The provider agreed to review these patients and include the alert in their review plan. | |

Effective

Effective needs assessment, care and treatment

| Prescribing | | | | |
|--|----------------------|-------------|-----------------|---------------------------------|
| Indicator | 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) (01/04/2017 to 31/03/2018) (NHSBSA) | 1.55 | 1.18 | 0.84 | Comparable with other practices |

People with long-term conditions

| Diabetes Indicators | | | | |
|--|--|--------------------|------------------------|---------------------------------|
| Indicator | Practice performance | 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 (01/04/2016 to 31/03/2017) (QOF) | 69.5% | 77.3% | 79.5% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 19.6% (67) | 15.8% | 12.4% | |
| Indicator | Practice performance | CCG average | England average | England comparison |
| 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 (01/04/2016 to 31/03/2017) (QOF) | 57.6% | 75.2% | 78.1% | Variation (negative) |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 22.8% (78) | 12.9% | 9.3% | |
| Indicator | Practice performance | 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 (01/04/2016 to 31/03/2017) (QOF) | 70.8% | 76.5% | 80.1% | Comparable with other practices |

| | | | | |
|-----------------------|---|---------------------------|-------------------------------|--|
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 19.9% (68) | 17.6% | 13.3% | |

| Other long term conditions | | | | |
|--|---|---------------------------|-------------------------------|----------------------------------|
| Indicator | 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 (01/04/2016 to 31/03/2017) (QOF) | 76.9% | 75.1% | 76.4% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 38.1% (128) | 14.6% | 7.7% | |
| Indicator | Practice | CCG average | England average | England comparison |
| 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 (01/04/2016 to 31/03/2017) (QOF) | 38.3% | 85.2% | 90.4% | Significant Variation (negative) |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 20.0% (30) | 13.0% | 11.4% | |
| 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 (01/04/2016 to 31/03/2017) (QOF) | 64.2% | 81.2% | 83.4% | Significant Variation (negative) |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 11.0% (101) | 6.4% | 4.0% | |
| Indicator | Practice | CCG average | England average | England comparison |
| 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 | 78.4% | 81.0% | 88.4% | Comparable with other practices |

| | | | | |
|----------------------------------|---|---------------------------|-------------------------------|--|
| (01/04/2016 to 31/03/2017) (QOF) | | | | |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 12.0% (12) | 8.1% | 8.2% | |

Any additional evidence or comments

Most of the above data relates to the previous provider of the service. The practice's most recent data, from March 2018 to May 2018, on the average daily quantity of Hypnotics prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR PU) is 0.41. The practice continued to monitor their prescribing in this area monthly, and actions were being implemented to reduce this. For example, regular reviews were undertaken with patients who were reducing these medicines and patients with complex needs were discussed in the multidisciplinary clinics.

The practice provided unverified QOF data from April 2017 to March 2018 for the above indicators for Kirkley Mill Surgery.

- 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 was 50%. The exception reporting was 9.1%.
- 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 was 46%. The exception reporting was 8.8%.
- 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 was 61%. The exception reporting was 8.8%.
- 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 was 45%. The exception reporting was 4.3%.
- 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 was 71%. The exception reporting was 13.6%.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less was 68%. The exception reporting was 5.8%.
- 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 was 74%. The exception reporting was 0%.

Families, children and young people

| Child Immunisation | | | | |
|---|------------------|--------------------|-------------------|---------------------------------|
| Indicator | Numerator | Denominator | Practice % | Comparison to WHO target |
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenzae type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2016 to 31/03/2017)(NHS England) | 46 | 49 | 93.9% | Met 90% minimum (no variation) |

| | | | | |
|---|----|----|-------|---|
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2016 to 31/03/2017) (NHS England) | 46 | 47 | 97.9% | Met 95% WHO based target (significant variation positive) |
| 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) (01/04/2016 to 31/03/2017) (NHS England) | 46 | 47 | 97.9% | Met 95% WHO based target (significant variation positive) |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2016 to 31/03/2017) (NHS England) | 46 | 47 | 97.9% | Met 95% WHO based target (significant variation positive) |

Any additional evidence or comments

This data relates to the previous provider of the service. The most recent unverified data from 2017 to 2018, provided by the practice, showed that:

- 99% of children aged 1, had completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)(i.e. three doses of DTaP/IPV/Hib).
- 91% of children aged 2 had received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster).
- 91% of children aged 2 had received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster).
- 90% of children aged 2 had received immunisation for measles, mumps and rubella (one dose of MMR).

The practice had completed an audit on children with a 'did not attend' code from November 2017 to July 2018 and found that 'in general, for all the patients that DNA, the standards of risk assessment, recording action/follow up and act were not met'. Actions had been identified and were being implemented and a further audit was planned for January 2019.

Working age people (including those recently retired and students)

| Cancer Indicators | | | | |
|--|----------|-------------|-----------------|---------------------------------|
| Indicator | 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) (01/04/2016 to 31/03/2017) (Public Health England) | 61.0% | 73.7% | 72.1% | Comparable with other practices |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE) | 66.3% | 76.4% | 70.3% | N/A |
| Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE) | 46.2% | 58.1% | 54.5% | N/A |
| The percentage of patients with cancer, | 26.2% | 66.0% | 71.2% | N/A |

| | | | | |
|---|-------|-------|-------|---------------------------------|
| diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (PHE) | | | | |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2016 to 31/03/2017) (PHE) | 41.4% | 49.6% | 51.6% | Comparable with other practices |

Any additional evidence or comments

This data relates to the previous provider of the service. The most recent unverified data from 2017 to 2018, provided by the practice, showed that:

- 72% 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).
- 58% of women aged between 50 to 70 had been screened for breast cancer in the last 36 months (3 year coverage).
- 94% of people aged 60 to 69, were screened for bowel cancer in the last 30 months (2.5 year coverage).
- 35 new cancer cases were treated. The detection rate was 15%, as four out of 27 two week wait referrals resulted in a cancer diagnosis.

A cervical screening exemption code audit was completed in January 2018. 177 patients were identified with an exemption codes and of those, 58 patient records were reviewed. A clear process was followed in 96.5% of patients. Actions were identified, for example, the wishes of two patients which were unclear from the records, were followed up, and a plan was in place to review the timescale of when to code for exemptions.

People experiencing poor mental health (including people with dementia)

| Mental Health Indicators | | | | |
|--|--|--------------------|------------------------|----------------------------------|
| Indicator | 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 (01/04/2016 to 31/03/2017) (QOF) | 31.9% | 88.4% | 90.3% | Significant Variation (negative) |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 20.2% (23) | 19.5% | 12.5% | |
| Indicator | Practice | CCG average | England average | England comparison |
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF) | 71.0% | 87.7% | 90.7% | Variation (negative) |

| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
|---|--|--------------------|------------------------|---------------------------------|
| | 18.4% (21) | 18.4% | 10.3% | |
| Indicator | Practice | CCG average | England average | England comparison |
| The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF) | 72.7% | 80.3% | 83.7% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 37.1% (13) | 9.0% | 6.8% | |

Any additional evidence or comments

This data relates to the previous provider of the service. The practice provided unverified QOF data from April 2017 to March 2018 for the above indicators for Kirkley Mill Surgery.

- 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 was 68%. The exception reporting was 21%.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 60%. The exception reporting was 21.8%.
- The percentage of patients diagnosed with dementia whose care plan had been reviewed in a face-to-face review in the preceding 12 months was 71%. The exception reporting was 16.2%.

Monitoring care and treatment

| Indicator | Practice | CCG average | England average |
|--|-------------|-------------|-----------------|
| Overall QOF score (out of maximum 559). | 428 (76.6%) | 530 | 539 |
| Overall QOF exception reporting (all domains). | 11.3% | 7.1% | 5.7% |
| Overall QOF score (unverified data 2017-2018) (out of maximum 559). | 430 (76.9%) | - | - |
| Overall QOF exception reporting (all domains) (unverified data 2017-2018) . | 14.9% | - | - |

Coordinating care and treatment

| Indicator | Y/N |
|--|-----|
| The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2016 to 31/03/2017) (QOF) | Yes |

Helping patients to live healthier lives

| 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 (01/04/2016 to 31/03/2017) (QOF) | 90.6% | 94.2% | 95.3% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 2.7% (43) | 1.1% | 0.8% | |

Any additional evidence

This data relates to the previous provider of the service. The practice provided unverified QOF data from April 2017 to March 2018 for the above indicators for Kirkley Mill Surgery.

- 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 was 95%. The exception reporting was 2%.

Consent to care and treatment

Description of how the practice monitors that consent is sought appropriately

In July 2018, the practice had completed an audit on recording who accompanied a child to appointments, in relation to ensuring appropriate consent was obtained. The audit found that from 100 records sampled, 72% of consultations had parental responsibility recorded appropriately in the consultation. Gillick competency was not properly recorded, although it may have been assessed. Identified actions were identified to improve the documentation of consent, both within the computer system and in the consultation record. A re-audit was planned for January 2019.

Caring

Kindness, respect and compassion

| CQC comments cards | |
|---|----|
| Total comments cards received | 14 |
| Number of CQC comments received which were positive about the service | 12 |
| Number of comments cards received which were mixed about the service | 2 |
| Number of CQC comments received which were negative about the service | 0 |

Examples of feedback received:

| Source | Feedback |
|------------------|--|
| Comments cards. | All the comments cards detailed positive comments about the service received. Patients reported staff as welcoming, helpful and informative. Two patients reported positively on the stop smoking service, which helped them to stop smoking. Two patients reported dissatisfaction with the appointment system, with having to phone in the morning to book an appointment. |
| Thank you cards. | The practice had received two thank you cards, which detailed appreciation of being treated with dignity. |

National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 6,359 | 297 | 108 | 36.36% | 1.7% |

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|---------------------------------|
| The percentage of respondents to the GP patient survey who stated that they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (01/01/2017 to 31/03/2017) | 59.2% | 82.9% | 78.9% | Comparable with other practices |
| The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at listening to them (01/01/2017 to 31/03/2017) | 78.2% | 90.4% | 88.8% | Comparable with other practices |
| The percentage of respondents to the GP patient survey who answered positively to question 22 "Did you have confidence and trust in the GP you saw or spoke to?" (01/01/2017 to 31/03/2017) | 84.3% | 95.9% | 95.5% | Variation (negative) |

| | | | | |
|--|-------|-------|-------|---------------------------------|
| The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern (01/01/2017 to 31/03/2017) | 76.7% | 87.0% | 85.5% | Comparable with other practices |
| The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at listening to them (01/01/2017 to 31/03/2017) | 88.4% | 93.2% | 91.4% | Comparable with other practices |
| The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern (01/01/2017 to 31/03/2017) | 93.9% | 91.5% | 90.7% | Comparable with other practices |

Any additional evidence or comments

The above data relates to the previous provider of the service. The most recent national GP Patient survey data was published in August 2018. 321 surveys were sent out and 93 were returned. This represented a 29% response rate.

- 85% of respondents reported that the last time they had a GP appointment, the healthcare professional was good at listening, compared with the CCG and national average of 89%.
- 81% of respondents reported that the last time they had a GP appointment, the healthcare professional was good at treating them with care and concern, compared with the CCG average of 88% and the national average of 87%.
- 88% of respondents reported that they had confidence and trust in the healthcare professional they saw or spoke to, compared with the CCG and national average of 96%.
- 67% of respondents described their overall experience of the GP practice as good, compared to the CCG and national average of 84%.

| Question | Y/N |
|---|-----|
| The practice carries out its own patient survey/patient feedback exercises. | Yes |

| Date of exercise | Summary of results |
|---|--|
| Patient survey undertaken in July 2018. | The practice received 28 patient responses. 89% of patients reported being happy with the services provided by the practice. 96% of patients reported finding staff helpful. 86% of patients reported that they felt involved in decisions about their health. 85% of patients would recommend the practice to their family and friends. |
| Friends and family feedback cards. | The practice had received two friends and family feedback cards for the month of August 2018, both of which stated that they were extremely likely to recommend the practice to friends and family. |

Involvement in decisions about care and treatment

Examples of feedback received:

| Source | Feedback |
|---------------------------|---|
| Interviews with patients. | All three patients we spoke with reported being involved in their care and treatment decisions. |

National GP Survey results

| Indicator | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|---------------------------------|
| The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at explaining tests and treatments (01/01/2017 to 31/03/2017) | 79.6% | 89.1% | 86.4% | Comparable with other practices |
| The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions about their care (01/01/2017 to 31/03/2017) | 66.7% | 85.3% | 82.0% | Comparable with other practices |
| The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at explaining tests and treatments (01/01/2017 to 31/03/2017) | 92.7% | 92.2% | 89.9% | Comparable with other practices |
| The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at involving them in decisions about their care (01/01/2017 to 31/03/2017) | 89.5% | 88.4% | 85.4% | Comparable with other practices |

Any additional evidence or comments

The above data relates to the previous provider of the service. The most recent national GP Patient survey data was published in August 2018. 321 surveys were sent out and 93 were returned. This represented a 29% response rate.

- 94% of respondents reported that the last time they had a GP appointment, they were involved as much as they wanted to be in decisions about their care and treatment, compared to the CCG average of 94% and national average of 89%.

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

| Carers | Narrative |
|---|---|
| Percentage and number of carers identified. | The practice had identified 105 patients as carers. This was approximately 1.6% of their practice population. |
| How the practice supports carers. | The practice coded carers and signposted them to support services, if appropriate. |
| How the practice supports recently bereaved patients. | The practice provided support to bereaved patients and signposted them to other sources of support, if appropriate. |

Privacy and dignity

| Question | Y/N |
|--|------------|
| Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. | Yes |

| | Narrative |
|---|---|
| Arrangements to ensure confidentiality at the reception desk. | A notice was written on a stand which was placed a slightly away from the reception area. This asked patients to wait there, until they were called by a receptionist, in the interests of patient confidentiality. A self check in screen was available for patients in the waiting area. Reception staff advised that they would offer patients a private room if they were distressed or wanted to discuss sensitive issues. There was no notice to advise patients of this, although they advised that a notice would be displayed. |

| Question | Y/N |
|---|------------|
| Consultation and treatment room doors were closed during consultations. | Yes |
| A private room was available if patients were distressed or wanted to discuss sensitive issues. | Yes |

Examples of specific feedback received:

| Source | Feedback |
|---------------------------|---|
| Interviews with patients. | One patient advised that patients could be overheard whilst at the reception desk, although they went on to confirm that they had never overheard any confidential or sensitive patient information. All the patients advised that their privacy and dignity was maintained by staff at the practice. |
| Interviews with staff. | Reception staff advised that they offered patients a private room to talk in, if they were upset to ensure confidentiality. |

Responsive

Responding to and meeting people's needs

| Practice Opening Times | |
|------------------------|------------------------------------|
| Day | Time |
| Monday | 8am to 6.30pm |
| Tuesday | 8am to 6.30pm |
| Wednesday | 8am to 6.30pm |
| Thursday | 8am to 6.30pm |
| Friday | 8am to 6.30pm |
| Appointments available | Monday to Friday 8.30am to 5.45pm. |
| Extended hours opening | No extended hours. |

| Home visits | Y/N |
|--|-----|
| The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. | Yes |
| If yes, describe how this was done | |
| Requests for home visits were triaged by the duty doctor. The duty doctor or advanced nurse practitioner undertakes the home visit, according to the clinical needs identified. The advanced nurse practitioner feeds back to the GP after the home visits have been undertaken to agree or further review the plan of care. | |

Timely access to the service

National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 6,359 | 297 | 108 | 36.36% | 1.7% |

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|---------------------------------|
| The percentage of respondents to the GP patient survey who were 'Very satisfied' or 'Fairly satisfied' with their GP practice opening hours (01/01/2017 to 31/03/2017) | 75.5% | 83.8% | 80.0% | Comparable with other practices |
| The percentage of respondents to the GP patient survey who gave a positive answer to 'Generally, how easy is it to get through to someone at your GP surgery on the phone?' (01/01/2017 to | 79.8% | 76.7% | 70.9% | Comparable with other practices |

| | | | | |
|--|-------|-------|-------|---------------------------------|
| 31/03/2017) | | | | |
| The percentage of respondents to the GP patient survey who stated that the last time they wanted to see or speak to a GP or nurse from their GP surgery they were able to get an appointment (01/01/2017 to 31/03/2017) | 65.4% | 77.4% | 75.5% | Comparable with other practices |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2017 to 31/03/2017) | 67.3% | 74.9% | 72.7% | Comparable with other practices |
| <p>Any additional evidence or comments</p> <p>The above data relates to the previous provider of the service. The most recent national GP Patient survey data was published in August 2018. 321 surveys were sent out and 93 were returned. This represented a 29% response rate.</p> <ul style="list-style-type: none"> • 81% of respondents reported that they found it easy to get through to someone at the practice on the phone, compared with the CCG average of 71% and national average of 70%. • 50% of respondents reported that they were satisfied with the general practice appointment times that were available, compared with the CCG average of 64% and national average of 66%. • 71% of respondents reported that they were satisfied with the type of appointment (or appointments) they were offered, compared with the CCG average of 77% and national average of 74%. • 62% of respondents described their experience of making an appointment as good, compared with the CCG average of 70% and the national average of 69%. • 94% of respondents, when thinking about the reason for their last general practice appointment, reported that their needs were met. This compared with the CCG average of 94% and the national average of 95%. | | | | |

Examples of feedback received from patients:

| Source | Feedback |
|--|---|
| Interviews with patients. | Two of the patients we spoke with were satisfied with the appointment system. One patient said there could be a delay in getting an appointment, but when there were no appointments available, a GP would phone and arrange a consultation if necessary. |
| Comments cards received from patients. | Two of the 14 patients reported dissatisfaction with the appointment system, with having to phone in the morning to book an appointment. |

Listening and learning from complaints received

| Complaints | Y/N |
|--|-------------------------|
| Number of complaints received in the last year. | 8 (since November 2017) |
| Number of complaints we examined. | 3 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 2 |

| | |
|--|---|
| Number of complaints referred to the Parliamentary and Health Service Ombudsman. | 0 |
| Additional comments: | |
| <p>The Suffolk GP Federation were reviewing their complaints policy, as they had recently established an electronic system (Datix) to record all events. They were keen to ensure that they had oversight of all complaints from this practice and their other services and could review and monitor improvements needed as well as identify trends.</p> <p>Before the inspection, we had been sent a spreadsheet of complaints, which showed that complaints were logged and reviewed, however the learning was not always specifically identified and the closure of some complaints was undertaken at a practice level. On the day of the inspection, managerial staff at the practice were not able to access the electronic system where complaints were logged and reviewed. The Director of Primary Care who had responsibility for complaint at the practice was not available on the day of the inspection and the Practice Services Director advised that the other manager dealt with this area. We reviewed the complaints system following the inspection.</p> <p>The Suffolk GP Federation had responsibility for logging and managing complaints. Complaints were recorded on the system by managerial staff at the practice and the Suffolk GP Federation sent reminders for staff at the practice to follow up on complaints according to set timescales. Consent for sharing information where people had complained on behalf of a patient were in place and followed. The final response letter for one complaint we reviewed was generated by the practice, rather than going through the agreed process. Consequently, the process for the escalation of complaints, if a patient was not satisfied had not been included. The provider was aware of this and were acting to ensure that the agreed reporting mechanisms were followed, for example by updating and enforcing their complaints policy.</p> | |

Well-led

Leadership capacity and capability

Examples of how leadership, capacity and capability were demonstrated by the practice

The Suffolk GP Federation became the provider on 1 November 2017; the practice had been placed into special measures under the previous provider. Since this time, they had worked to improve the known issues at the practice and had also identified additional issues, which had been addressed.

There was a GP clinical lead who had commenced in post in January 2018. The Suffolk GP Federation had employed a primary care medical director, who provided leadership across all the primary care services, which included Kirkley Mill Surgery. There was a lead nurse at the practice. Two of the regular locums, a GP and an advanced nurse practitioner had agreed to become permanent members of staff. This was due to take effect from 1 October 2018. The practice had not been successful in recruiting a full-time practice manager, so this role continued to be undertaken by the Director of Primary Care and the Practice Services Director from Suffolk GP Federation.

Practice staff told us that the Suffolk GP Federation and the new management team worked with them as a team, to overcome the shortfalls of the practice. They told us that improvements had been made with the introduction of more effective systems, processes and clear leadership. For example, a range of documented meetings, clear and agreed policies and procedures and having a permanent GP clinical lead based at the practice.

Vision and strategy

Practice Vision and values

The aim of the Suffolk GP Federation was 'to improve the health of the community we serve by reducing inequalities, providing safe, high-quality services using innovative models of care while ensuring the patient is at the heart of everything we do. We are dedicated to improving and protecting the long-term sustainability of primary care - helping to meet the physical, mental and social care needs of the population we serve.'

All the staff we spoke with understood the five core values of the Suffolk GP Federation. These were:

- Patient centred and continuity of care
- Exceptional care for all patients, particularly those from deprived and marginalised communities
- The highest clinical quality and the best patient experience
- Teamworking and collaboration
- Nurturing talent and fostering innovation.

Culture

Examples that demonstrate that the practice has a culture of high-quality sustainable care

The Suffolk GP Federation culture was based on being a not for profit organisation that was working to meet the demands of primary care within the resources available. They focused on patient care and bringing services closer to the patient, for example by contributing to the funding of 'Solutions.' This was a service based in the practice, which offered 45 minute appointments with patients, to sign post and support patients with a wide range of needs which included for example, social, housing and financial

needs. Patients could self-refer.

Practice staff told us the leadership was democratic and open, and that their views had been included with the changes made. The management team used and shared the management tools available to review issues identified, implement changes and monitor outcomes to ensure they were effective.

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

| Source | Feedback |
|-------------------------------------|---|
| Reception and administration staff. | Weekly admin team meetings had been established which staff said were useful to discuss any concerns and ideas. Staff reported there was always someone to go to for advice. |
| Reception staff. | Staff reported their views and ideas for improvement were listened to. For example, the prescriptions for patients on weekly and daily prescriptions used to be undertaken when time was available, in between reception and administration duties. There is now dedicated time for these to be completed without disruption. |
| Nursing staff. | Nursing staff reported that advice and support was easily available. Suggestions for clinical improvement were listened to and implemented. For example, Public Health England guidelines for urine testing had been implemented. |

Governance arrangements

| Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care. | |
|--|---|
| Practice specific policies. | The practice had a comprehensive suite of policies and procedures which were managed at a senior level but were completed with practice specific details. All staff had easy access to them. These were all in date. These were not all embedded at the practice. |
| Lead Roles. | The Suffolk GP federation and practice had identified staff in lead roles, which included for example, safeguarding, infection control and information governance. |
| Monitoring of mandatory training completion. | The practice had established a system to identify and monitor that staff had received mandatory training appropriate to their role. |
| Assurance of advanced nurse practitioner work. | The work undertaken by advanced nurse practitioners was formally reviewed to obtain assurance of the quality of their work. |
| | Y/N |
| Staff were able to describe the governance arrangements. | Yes |
| Staff were clear on their roles and responsibilities. | Yes |

| Any additional evidence |
|--|
| <p>The practice used an electronic system (Datix) to record all events. The management team for the Suffolk GP Federation had oversight of all these and their other services and could review and monitor improvements needed as well as identify trends.</p> <p>On the day of the inspection, managerial staff at the practice were not able to access the electronic system where significant events and complaints were logged. Staff we spoke with were not all aware of the outcomes of significant events. The process of learning from significant events and complaints was</p> |

not embedded at a practice level.

Managing risks, issues and performance

| Major incident planning | Y/N |
|--|-----|
| Major incident plan in place. | Yes |
| Staff trained in preparation for major incident. | No |
| Any additional evidence Staff at the practice had not received training in preparation for a major incident. There was no health and safety or premises risk assessment and appropriate emergency medicines were not available and no risk assessment had been undertaken. | |

Examples of actions taken to address risks identified within the practice

| Risk | Example of risk management activities |
|------------------------------|--|
| Identified risks acted upon. | An action plan was written when Suffolk GP Federation became the provider for Kirkley Mill Surgery. Identified outcomes had been identified and many had been achieved. There was a process in place for monitoring progress. |
| Summarising. | Summariser had hours increased temporarily. Additional summariser recruited and employed. Summarising protocol updated. Read code training completed by all staff. A significant number of patient's notes had been summarised since our last inspection although approximately 1,000 still needed to be summarised. |
| Clinical capacity. | Patients who lived at a sheltered housing scheme were risk assessed for their ability to attend the practice for a consultation, rather than a home visit. This increased clinician capacity by reducing unnecessary home visits. The learning from this was planned to be extended to all housebound patients and audited. |
| GP and clinician continuity. | The practice had reduced the number of locum GPs from five (January 2018) to two. One of these locums had been recruited as a permanent member of staff and was due to transfer in October 2018. One of the locum advanced nurse practitioners had been recruited as a permanent member of staff and was also due to transfer in October 2018. |

Appropriate and accurate information

| Question | Y/N |
|---|-----|
| Staff whose responsibilities include making statutory notifications understood what this entails. | Yes |

Engagement with patients, the public, staff and external partners

Feedback from Patient Participation Group (PPG);

| Feedback |
|---|
| The practice had recently established a PPG. The PPG chairperson advised that there had only been three meetings so far. They advised that staff from the practice attended the meetings, were open and |

honest and questions raised were answered. There was a definite interest in trying to improve the practice. Minutes of the meetings were displayed on the PPG notice board in the waiting area. There was evidence that the practice had responded to suggested improvements from patients. For example, sanitising gel was available next to the self check in screen.

| Any additional evidence | |
|----------------------------------|--|
| Responding to staff suggestions. | Room names had been originally named after local windmills. It was suggested that these should be changed to the name of the clinician who the patients were seeing in the room. |
| Staff newsletter. | All staff were emailed a monthly newsletter from the Suffolk GP Federation. |
| Staff Council. | The Suffolk GP Federation had established a staff council, which had its first meeting in July 2018. It was planned that the meetings would occur every three months. Each practice had a representative, who was decided by the practice. |
| Friends and family feedback. | The practice noted the comments that were fed back through this system and acted to address any issues raised. |

Continuous improvement and innovation

Examples of improvements demonstrated as a result of audits in past two years.

| Audit area | Improvement |
|---|---|
| A two-cycle clinical audit undertaken in August 2018 of the prescribing of co-amoxiclav, cephalosporin and quinolones. | This showed a reduction in the prescribing of cephalosporin and quinolones, but an increase in their prescribing of co-amoxiclav, since November 2017. Actions had been identified which included, a clinical education session for a clinical meeting, a pop up alert to be added to alert clinicians and a copy of the CCG antibiotic formulary to be available in every clinical room, including the locum pack. |
| The practice had completed a place of death audit in May 2018 which identified that patients who had a do not attempt cardio-pulmonary resuscitation (DNACPR) documented and who were on the palliative care register were more likely to die at home. Actions were identified for example, to discuss advanced care planning including DNACPR and preferred place of care at end of life and to increase the use of DNACPR and palliative care coding. | A repeat audit in July 2018, showed that the number of patients with a DNACPR documented had increased from 22% to 23% and the number of patients on the palliative care register had increased from 29% to 41%. |
| Home visits. | The number of home visits in November 2017 was 148, January 2018 was 135, and June 2018 was 51. A protocol for home visits was in place and home visit requests continued to be triaged by the duty GP. This had significantly increased GP capacity. |

DO NOT DELETE THE NOTES BELOW

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 comparable, 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 comparable 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 Band | Z-score threshold |
|---|----------------------------------|-------------------|
| 1 | Significant variation (positive) | $Z \leq -3$ |
| 2 | Variation (positive) | $-3 < Z \leq -2$ |
| 3 | Comparable to other practices | $-2 < Z < 2$ |
| 4 | Variation (negative) | $2 \leq Z < 3$ |
| 5 | Significant variation (negative) | $Z \geq 3$ |
| 6 | No data | Null |

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.

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:

<http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework (see <https://qof.digital.nhs.uk/>).
- **RCP:** Royal College of Physicians.
- **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. (See NHS Choices for more details).