

# Care Quality Commission

## Inspection Evidence Table

**Dr Girija Kugapala (1-496379288)**

**Inspection date: 14 March 2019**

**Date of data download: 1 March 2019**

## Overall rating: Good

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

### Effective

### Rating: Good

#### Effective needs assessment, care and treatment

**Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools. Staff proactively engaged and encouraged patients to access care and treatment.**

	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
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 were in place 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
Explanation of any answers and additional evidence: Regular clinical meetings took place where best practice guidelines including NICE guidelines were discussed. Care and care plans were appropriate including for patients with diabetes, cancer, a learning difficulty asthma, and mental health.	

## 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.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks were offered to patients over 75 years of age.

## People with long-term conditions

## Population group rating: Good

### Findings

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

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	85.3%	71.3%	78.8%	No statistical variation
Exception rate (number of exceptions).	1.1% (5)	6.9%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	98.7%	79.8%	77.7%	Significant Variation (positive)
Exception rate (number of exceptions).	0 (0)	5.0%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	93.3%	79.7%	80.1%	Significant Variation (positive)
Exception rate (number of exceptions).	2.5% (12)	7.5%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	100.0%	78.4%	76.0%	Significant Variation (positive)
Exception rate (number of exceptions).	1.6% (4)	3.0%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	100.0%	92.1%	89.7%	No statistical variation
Exception rate (number of exceptions).	0 (0)	6.8%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	98.4%	81.7%	82.6%	Significant Variation (positive)
Exception rate (number of exceptions).	1.0% (5)	3.2%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	100.0%	88.8%	90.0%	No statistical variation

Exception rate (number of exceptions).	0 (0)	5.7%	6.7%	N/A
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### Any additional evidence or comments

The practice QOF performance was above local and national averages including with lower than average exception reporting. Staff told us the practice was a focal point in the community and patients and staff were well connected within the local community; particularly as 74% of the practice list was from Sri Lanka and most staff spoke Tamil. Staff contacted and recalled patients proactively to explain and encourage patients to receive care and treatment.

## Families, children and young people

## Population group rating: Good

### Findings

- Childhood immunisation uptake rates were above the World Health Organisation (WHO) targets.
- 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.
- 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.
- Young people could access services for sexual health and contraception.

Child Immunisation	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 influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	67	67	100.0%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	65	70	92.9%	Met 90% minimum (no variation)
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) (01/04/2017 to 31/03/2018) (NHS England)	65	70	92.9%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR)	65	70	92.9%	Met 90% minimum (no variation)

(01/04/2017 to 31/03/2018) (NHS England)				
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### Any additional evidence or comments

The practice performed strongly in its coverage data for child immunisations, it exceeded World Health Organisation (WHO) targets for child immunisations for children one and two years old and achieved significantly higher coverage of 100% for children aged one. This was due to staff contacting parents and recalling patients to encourage them to receive child immunisations.

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

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	79.4%	62.9%	71.7%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	74.1%	55.0%	70.0%	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)	78.6%	45.2%	54.6%	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%	80.7%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	83.3%	43.9%	51.9%	No statistical variation

### Any additional evidence or comments

The practice cancer screening coverage rates were higher than local and national averages for all cancer screening data. This was due to staff contacting and recalling patients to encourage uptake.

### People whose circumstances make them vulnerable

**Population group rating: Good**

#### Findings

- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. All 11 patients with a learning disability had received an annual health review.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice reviewed young patients at local residential homes.

### 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.
- 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.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	93.8%	90.3%	89.5%	No statistical variation
Exception rate (number of exceptions).	0 (0)	8.4%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption	93.8%	91.7%	90.0%	No statistical variation

has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	0 (0)	4.9%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	100.0%	84.8%	83.0%	Variation (positive)
Exception rate (number of exceptions).	0 (0)	4.3%	6.6%	N/A

#### Any additional evidence or comments

The practice performance data for mental health was above average with exception reporting rates of zero. Care plans we checked demonstrated effective engagement and care and support for with people with mental health conditions.

#### 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)	559.0	510.0	537.5
Overall QOF exception reporting (all domains)	1.5%	5.1%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

In the last two years:
<p>The practice had undertaken completed and single cycle audits relating to patients:</p> <ul style="list-style-type: none"> <li>• Prescribed high risk medicines</li> <li>• Asthma care plans</li> <li>• Helicobacter pylori infection eradication for patients with indigestion</li> <li>• Kidney functioning in patients with high blood pressure</li> <li>• Prescribed multiple medicines</li> <li>• With retinal problems and diabetes</li> </ul>



- Osteoporosis management

Completed (two cycle) audits included:

1. An audit to ensure correct monitoring of patients prescribed high risk medicines. In the first audit cycle 12 patients that required monitoring were monitored appropriately. Clinicians met to review, remind and recirculate best practice guidelines and set up a protocol to ensure standards would be maintained. In the second cycle audit of 11 patients all were appropriately monitored.
2. An audit to check patients had an appropriate asthma action plan to ensure they were educated regarding the best way to control their condition. In the first cycle five of six patients (83%) had an appropriate asthma care plan. Clinicians including nursing staff met to refresh their awareness and understanding of best practice guidelines. Relevant patients care plans were reviewed and a second sample audit cycle was undertaken of four patients and all (100%) had an appropriate asthma care plan.

## 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 saw staff were able to manage data and by using internal systems effectively in accordance with their roles. For example, referrals to other services were prompt, well documented and followed up.	
The practice regularly audited cervical screening “inadequate” sample tests and rates were low which indicated sample takers competence.	



## Coordinating care and treatment

**Staff worked together and with other organisations to deliver effective care and treatment, but there was a backlog of hospital letters many not confirmed as read or received.**

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Regular clinical meetings took place where best practice guidelines including NICE guidelines were discussed.</p> <p>Care and care plans were appropriate including for patients with diabetes, COPD, and mental health.</p> <p>There was no backlog of patients test results on the IT system.</p> <p>The practice had implemented a new system being trialled in the local Clinical Commissioning Group (CCG) area from 19 November 2018. The process was intended to free up clinician's time to provide more appointments by allowing trained non-clinical staff to open and action patient's paper correspondence, including clinical correspondence such as hospital letters. These letters had been dealt with to the end of 2018. However, there were over 100 letters in the incoming correspondence tray dating back to 7 January 2019 that we random sample checked and found several containing relevant clinical information that was not confirmed as being conveyed to the GP or recorded on the IT system. This meant if the patient had come in for a consultation the GP would not have been aware of relevant clinical information that may have informed their decision on the best course of care or treatment. The quality monitoring auditing system for the new document management process was limited and had not identified that important information was not being promptly recorded or brought to the attention of the GP. We found no evidence of patient harm or urgent / critical clinical matters not being dealt with. However, our random sample check identified a significant number of examples of patient information that should have been brought to GPs attention, and recorded on the IT system for clinician's consideration for patients most appropriate care and treatment, including:</p> <ul style="list-style-type: none"> <li>• A hospital consultant's recommendation for a patient to have a blood sugar tests done during January 2019 and there was no evidence it had been actioned.</li> <li>• A letter showing a patient had an infection that was resolved, which should have been on the IT system for clinicians to consider in case of potential impact on future care and treatment decisions, for example recurrence of infection.</li> <li>• A patient whose blood tests results indicated they needed a liver scan and no evidence this had yet been considered.</li> </ul>	

- A patient that had not attended their hospital appointment for a scan and was advised to contact their GP if feeling unwell. There was no evidence a GP had seen the letter to consider whether to rebook the scan.

There was no clear audit trail to ensure relevant care and treatment was delivered, some letters were duplicated and not cross checked and it was not clear which was which.

We found no correspondence requiring urgent action or evidence of patient harm.

The practice triggered its significant events procedure on the day of our inspection. Within two days of our inspection the practice sent us evidence it had assessed and mitigated all risks on a patient by patient basis and identified no patient harm. To prevent recurrence staff agreed all letters and reports received in the future will initially be brought to the attention of a GP and once reviewed and actions noted on the letter/report non-clinical staff will follow up appropriately and scan letters onto the IT system all within three days of initial receipt. Leadership staff told us all staff will be provided appropriate support and training.

## 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
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:	
There was varied health promotion in the reception area including relating to immunisations and common ailments.	
Patients feedback and care plans indicated staff encouraged and educated patients appropriately to help patients live healthier lives.	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	100.0%	96.5%	95.1%	Significant Variation (positive)

Exception rate (number of exceptions).	0.2% (2)	0.7%	0.8%	N/A
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#### Any additional evidence or comments

The above average performance for recording smoking for specific groups of patients was due to staff contacting, staff also encouraged patients to access smoking cessation programs.

### 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
Explanation of any answers and additional evidence: We checked records for implants, cervical screening, and immunisations and saw evidence patients consent was sought and recorded.	

## Well-led

**Rating: Good**

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: There was a contingency plan for the event of unplanned absence of the lead GP. The practice was in the process of formalising a succession plan in partnership with a neighbouring practice.	

### 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: Practice staff confirmed they wanted to do all they could to ensure patients had the right care when they needed it most. Staff were able to articulate the values and priorities of the practice.	

**Culture**

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
Explanation of any answers and additional evidence: Staff had access to and whistleblowing policy and told us there was an open working culture. Staff requested high backed office chairs for desk-based working which had been provided. The practice staff team said there was an open and accessible leadership and management team that were focused on providing high and improving standards. Complaints and significant events information showed the practice was open and honest with patients and apologised to patients, where appropriate.	

**Governance arrangements**

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

	Y/N/Partial
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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:	
There were a variety of internal and external meetings, including where staff discussed complaints and significant events that resulted in learning and improvement.	
Practice specific policies were in place and accessible via a shared desktop folder and hard copy.	

## 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.	Partial
Explanation of any answers and additional evidence:	
<p>There were clear systems and processes for safeguarding including registers and alerts for protected and vulnerable patients. Staff were appropriately trained in safeguarding at a level appropriate to their role.</p> <p>GP Patient survey results for the practice were comparable to local and national averages.</p> <p>The practice had undertaken its own patient's satisfaction survey where results aligned with the GP Patient survey results and indicated patients were satisfied.</p> <p>In November 2018 the practice had implemented a new document management system to free up and make better use of clinician's time by arranging for non-clinical staff to action patients incoming paper clinical correspondence, including hospital letters but the impact on quality and sustainability had not been fully assessed. Quality auditing systems had not confirmed or evaluated whether necessary information contained in clinical correspondence was actioned or recorded on the IT system, to ensure GPs awareness. The practice triggered its significant events process on the day of our inspection and implemented appropriate arrangements to manage risks and improve safety.</p>	

## 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:	
The practice used data such as benchmarking and its QOF performance and GP Patient survey data to monitor and improve care.	
Staff performance appraisals were undertaken annually.	
Staff were multilingual and conveyed comprehensive and accurate information by proactively explaining care and treatment options to patients, including those that spoke English as a second language (predominantly Tamil).	

## 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
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:	
The practice was aware of and provided its services in line with local needs and in line with best practice guidelines.	
There was no information in non-English languages in the reception area, but the practice engaged with patients through surveys and sharing information, and many staff spoke other languages. The practice had advertised and promoted its extended hours clinic, introduced a whiteboard to clarify any delays to patients waiting time, and increased its GP provision to provide more evening appointments to sustain and improve patient satisfaction.	
Staff went on social events and outings together and told their ideas were listened to, and that it was a cohesive and caring staff team that felt motivated and supported.	

Feedback from Patient Participation Group.

## Feedback

The PPG was complimentary about the practice and its staff and told us there was a positive and proactive partnership working relationship.

The PPG had submitted proposals for reducing patient's prescriptions charges and suggesting providing educational events for patients that were implemented and helpful.

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
A range of continuous clinical improvement activity such as clinical audits.	
The practice was involved in local pilots to underpin and inform improvements in the local area and to its patients including to reduce the incidence and spread of tuberculosis (TB) and ensure care plans for patients at the end of life were co-ordinated with allied health and social care professionals.	

### 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 Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	No statistical variation	$-2 < Z < 2$
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.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

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



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

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

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