

Care Quality Commission

Inspection Evidence Table

Dr S Nelson & Partners (1-589508826)

Inspection date: 16 July 2019

Date of data download: 10 July 2019

Overall rating: Good

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

Effective

Rating: Good

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence: The practice used Arden's templates to provide comprehensive care plans to patients (Arden's is a clinical decision support tool). We reviewed care plans for patients diagnosed with asthma and diabetes and found clear guidance was given to patients on the management of their condition. For example, for patients diagnosed with asthma, the care plan included guidance on what they should do should they experience an exacerbation of their condition. The practice held daily satellite clinics at two local schools. Clinicians employed by the practice would	

attend these clinics on a rotational basis.

The practice had a system for following up children on their safeguarding register who failed to attend secondary care appointments. However, the practice did not have a system to follow up children who were not on this register who failed to attend these appointments. The practice was aware that they needed to improve on this process and they were looking to introduce a revised protocol. Following inspection, the provider sent us evidence that this had been actioned.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) <small>(NHSBSA)</small>	0.74	0.84	0.77	No statistical variation

Older people

Population group rating: Good

Findings

- The practice employed a dedicated frailty nurse who conducted home visits for older patients.
- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.

- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with asthma were offered an asthma management plan.
- Out of seven indicators for patients with long term conditions, two showed that exception reporting was above (worse than) local and national averages.

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) <small>(QOF)</small>	74.8%	81.0%	78.8%	No statistical variation
Exception rate (number of exceptions).	15.9% (66)	18.5%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	87.3%	78.6%	77.7%	Tending towards variation (positive)
Exception rate (number of exceptions).	12.5% (52)	13.9%	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) <small>(QOF)</small>	80.9%	80.9%	80.1%	No statistical variation
Exception rate (number of exceptions).	21.7% (90)	17.7%	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) <small>(QOF)</small>	71.1%	76.7%	76.0%	No statistical variation
Exception rate (number of exceptions).	1.9% (16)	8.9%	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) <small>(QOF)</small>	91.5%	91.8%	89.7%	No statistical variation
Exception rate (number of exceptions).	25.0% (43)	14.4%	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)	82.3%	83.4%	82.6%	No statistical variation
Exception rate (number of exceptions).	1.9% (23)	4.8%	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)	84.5%	92.0%	90.0%	No statistical variation
Exception rate (number of exceptions).	5.7% (11)	6.4%	6.7%	N/A

Any additional evidence or comments

We reviewed unverified data for 2018/2019 QOF exception reporting;

- The percentage of patients who were exception reported 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 19.3%.

The practice was aware that their exception reporting was higher than local and national averages. The practice advised that several the patients that had been exception reported had underlying medical conditions which meant that this intervention was not appropriate.

Families, children and young people

Population group rating: Good

Findings

- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets in three indicators and in line with national targets for one indicator.
- Patients attending the practice for childhood immunisations were given a 30-minute appointment with the nurse to discuss any areas of concern.
- The practice operated daily clinics at two local schools.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.
- The practice had arrangements for following up failed attendance of children's appointments for immunisation and would liaise with health visitors when necessary.
- At the time of inspection, practice did not have a formal process to follow up all failed attendance of children's appointments following an appointment in secondary care.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib) ((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	106	111	95.5%	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)	103	110	93.6%	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 (Men) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)	106	110	96.4%	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) (01/04/2017 to 31/03/2018) (NHS England)	105	110	95.5%	Met 95% WHO based target (significant variation positive)

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

Any additional evidence or comments

We discussed the practice's uptake of child immunisations and reviewed unverified data for 2018/2019;

- 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) was 96.9%
- The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) was 92%.
- The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (Men) (i.e. received Hib/MenC booster) was 91.1%.
- The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) 92.0%.

While there was a slight reduction in achievement for 2018/2019, uptake still exceeded national targets across all indicators and exceeded the World Health Organisation target in one indicator.

The practice told us that each child who did not attend the practice for their immunisations, would be reviewed by a nurse. If they had not already rescheduled their appointment, the nurses would contact the parent or guardian to discuss the reasons for not attending.

The practice advised that when patients attended the practice for child immunisations, they were given a 30-minute appointment with the nurse enabling them to discuss any issues or concerns.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- 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)	73.5%	76.1%	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)	75.8%	75.1%	69.9%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	58.8%	61.5%	54.4%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	62.3%	71.3%	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)	39.6%	53.9%	51.9%	No statistical variation

Any additional evidence or comments

We reviewed unverified data for 2018/2019 from Public Health England and found that the practice had improved uptake for cervical smears as follows;

- 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) was 79.7%.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

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

- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.

**People experiencing poor mental health
(including people with dementia)**

Population group rating: Good

Findings

- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	100.0%	93.0%	89.5%	Variation (positive)
Exception rate (number of exceptions).	54.3% (50)	18.0%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	94.3%	91.6%	90.0%	No statistical variation
Exception rate (number of exceptions).	42.4% (39)	15.9%	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) <small>(QOF)</small>	100.0%	87.4%	83.0%	Significant Variation (positive)
Exception rate (number of exceptions).	5.0% (6)	7.5%	6.6%	N/A

Any additional evidence or comments

We reviewed unverified 2018/2019 QOF exception reporting data;

- The percentage of patients who were exception reported 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 35.5%.
- The percentage of patients who were exception reported with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 39.1%.

The practice was aware that their exception reporting for these indicators was higher than local averages. This was investigated on the day of inspection and found that some patients were coded incorrectly on their system and instead of them being removed from the register, they had been exception reported. For instance, it was identified that some patients on the register were in remission and had not been coded appropriately. Instead, they had been exception reported.

On inspection, the practice conducted a search for the above indicator and excluded the patients who were coded incorrectly. Their findings were as follows;

- The percentage of patients who were exception reported 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 14.3%.
- The percentage of patients who were exception reported with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 20%.

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)	550.7	548.4	537.5
Overall QOF score (as a percentage of maximum)	98.5%	98.1%	96.2%
Overall QOF exception reporting (all domains)	5.9%	6.3%	5.8%

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

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.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:	
The practice did not have current systems in place to monitor the prescribing competencies of advanced nurse practitioners. One member of staff we spoke with advised that no audits had been conducted for their prescribing practices. However, we were told that advanced nurse practitioners were supported by a GP mentor and that clinical supervision was due to start. Following inspection, the provider confirmed that they had since implemented processes to monitor non-medical prescribers.	

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y

Explanation of any answers and additional evidence:

The practice took an active role in a local medical council (LMC) initiative which encouraged GP practices to maintain care and treatment for patients who become residents of a care home or hospice outside of their practice's catchment. This was to ensure continuity of care was maintained for patients. The practice had also engaged with other primary care providers in the local area to encourage this coordination for patients who had become residents of the care homes registered with the practice.

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y

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) <small>(QOF)</small>	93.0%	94.2%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.6% (15)	0.8%	0.8%	N/A

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance however this was not monitored.

	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.	N
Policies for any online services offered were in line with national guidance.	Y
Explanation of any answers and additional evidence: We saw evidence that consent was obtained in line with national guidance. However, we did not see evidence that the provider monitored if this process was consistent across the practice. Following inspection, the practice advised that they would reintroduce a system to monitor this.	

Well-led

Rating: Requires Improvement

We rated the practice as requires improvement for providing well led services. We found that;

- Governance arrangements required strengthening to ensure risks were mitigated
- Processes to support good governance were not fully comprehensive.

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

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

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y

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

Source	Feedback
Interviews with staff	Feedback included; <ul style="list-style-type: none"> • There were positive relationships between staff and clinicians. • Staff felt supported in their roles.
CQC questionnaire	staff Feedback included; <ul style="list-style-type: none"> • All staff were friendly and supportive. • The doctors and management were approachable.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management, but these were not always comprehensive.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: The practice had a significant event policy however, we saw that the policy was not fully comprehensive. It did not identify what would constitute as a significant event and did not detail what steps should be taken if a patient was affected by an event. Following inspection, the practice sent us evidence that they had since updated their policy to make it more comprehensive. We found that complaints were dealt with in line with practice policy. However, the practice's policy identified that formal complaints were required in writing. We discussed this with the practice on inspection as this could mean that the ability to place a formal complaint might not be accessible to all	

patients. The practice advised that they would amend their policy. Following inspection, the practice sent us evidence to show that this had been actioned.

The practice did not have a process to monitor whether consent was consistently obtained and recorded appropriately. Following inspection, the provider advised that they would reintroduce a system to monitor this.

Managing risks, issues and performance

There were processes for managing risks, issues and performance but these were not always embedded.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	partial
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed the practice's business continuity plan. It detailed what steps should be taken for several adverse events including fire and flooding. The practice told us that all key members of staff had a copy of the policy and a copy was also kept off site in case the premises was inaccessible.</p> <p>Staff had received appraisals in line with practice policy. The practice advised that they were due to introduce internal appraisals for salaried GPs.</p> <p>The practice had implemented systems to identify potential risk to staff and patients through risk assessments. We saw evidence of risk assessments for infection prevention and control, fire and Legionella. However, processes to ensure that risk was recorded and managed appropriately were not always effective. For example, it had not been recorded when items requiring action on the fire risk assessment had been completed. For Legionella, we reviewed the log of water temperature checks conducted by the practice and found that these were out of range. The practice advised that this was a result of the cleaners turning the tap water heaters off. This mitigation was not recorded, and the water temperatures had not been re-tested.</p> <p>Processes to ensure the competency of non-medical prescribers such as advanced nurse practitioners (ANPs), was not embedded.</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
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

Explanation of any answers and additional evidence:
 Following patient feedback, the practice introduced a new telephone system. This gave increased functionality and reduced the amount of time patients spent trying to get through to the practice. It also included a welcome message which explained the need for reception staff to ask patients questions to appropriately direct their call.

Feedback from Patient Participation Group.

Feedback
 Feedback included that the practice was open and honest and always looked for ways to improve. They were prepared to listen to what the patient participation group had to say and that they had a positive working relationship.

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: The practice was looking to introduce 15-minute appointments as a way of reducing the amount of time patients were waiting for their appointment in reception area.	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

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

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

Glossary of terms used in the data.

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