

# Care Quality Commission

## Inspection Evidence Table

### Park Road Group Practice (1-550978152)

Inspection date: 14<sup>th</sup> January 2020

Date of data download: 06 January 2020

## Overall rating: Good

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

### Effective

### Rating: Good

#### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>The triage system worked to offer patients appointments the same day. Patients received a telephone consultation from the GP who would then decide what treatment was necessary and whether a face to face consultation was required.</li><li>Staff ensured that patients referred through the two-week wait pathway had received a hospital appointment before they left the practice. to ensure that they received timely care.</li></ul>	

- Patients were provided with information about signs to look for that would indicate health deterioration. This included a small card with key signs of sepsis that was available to all patients.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>	0.99	1.04	0.74	No statistical variation

## Older people

## Population group rating: Good

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. The practice maintained a frailty register to ensure the needs of this group were reviewed and met. 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.
- Home visits were offered for medical appointments and reviews.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice worked with community services including district nurses and held regular multidisciplinary team meetings.

## People with long-term conditions

## Population group rating: Good

### Findings

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

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	85.0%	79.0%	79.3%	No statistical variation
Exception rate (number of exceptions).	19.6% (99)	13.5%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) (QOF)	85.8%	78.4%	78.1%	No statistical variation
Exception rate (number of exceptions).	6.9% (35)	10.0%	9.4%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	89.5%	83.5%	81.3%	Tending towards variation (positive)
Exception rate (number of exceptions).	15.4% (78)	12.3%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	76.4%	74.9%	75.9%	No statistical variation
Exception rate (number of exceptions).	2.0% (13)	9.2%	7.4%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	92.6%	88.6%	89.6%	No statistical variation
Exception rate (number of exceptions).	3.7% (13)	9.3%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) (QOF)	86.5%	82.8%	83.0%	No statistical variation
Exception rate (number of exceptions).	2.7% (36)	4.8%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) (QOF)	91.5%	90.5%	91.1%	No statistical variation
Exception rate (number of exceptions).	5.7% (10)	6.0%	5.9%	N/A

## Families, children and young people

## Population group rating: Good

### Findings

- The practice had not met the minimum 90% target for any of the four childhood immunisation uptake indicators. The WHO based national target is 95% (the recommended standard for achieving herd immunity). This was discussed in practice meetings and an action plan was in place to drive improvements.
- 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.
- All parents or guardians calling with concerns about a child were offered appointments with a clinician on the same day with flexible times for appointments offered.
- 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.
- Patients were referred to local services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	64	73	87.7%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	65	73	89.0%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	65	73	89.0%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	65	73	89.0%	Below 90% minimum

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

#### Any additional evidence or comments

- The practice were working towards improving attendance for childhood immunisations. The practice contacted the parents or guardians of children due to have childhood immunisations. Letters, telephone calls and a text service was used. Due to increased numbers of patients who spoke English as a second language, the practice had translated the invitation letter about immunisations into the six most commonly used first languages.
- Staff provided information and encouraged uptake of immunisations opportunistically when patients attended the practice.
- Children who had not been vaccinated with their cohort were referred to a community immunisation team.

## 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. The practice actively used a text messaging service to communicate with patients about services and to remind them about appointments.
- Patients were able to access telephone appointments and use online consultation and prescription services which assisted those who found it difficult to attend the practice.
- Appointments were available from 8am with extended hours until 8:30pm on a Monday. The triage service allowed flexibility and short notice appointments to suit the best time for the patient.

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). (31/03/2019 to 30/06/2019) (Public Health England)	75.7%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	67.2%	64.0%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	51.0%	50.1%	58.0%	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. (01/04/2018 to 31/03/2019) (PHE)	76.5%	74.9%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	55.3%	47.4%	53.8%	No statistical variation

### Any additional evidence or comments

The practice was monitoring the attendance of patients attending for cervical cancer screening. The practice used alerts on patient records who were due for screening but had not attended. Screening was offered opportunistically. The practice sent letters and text messages to invite and remind patients of appointments.

The practice had plans in place to further encourage attendance including a women's health event.

### **People whose circumstances make them vulnerable**

**Population group rating: Good**

#### **Findings**

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. There was a lead GP for patients approaching the end of their lives to ensure care was provided appropriately.
- 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 and liaised with community drug and alcohol services. Weekly substance misuse clinics were held at the practice by a community team to support patients.

### **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. They provided access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to smoking cessation services.
- Same day and longer appointments were offered when required.
- 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. The triage system used by the practice meant that all patients at risk were seen the same day and referrals to the community mental health team were made appropriately.
- 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.



- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services. This included promotion of self-referral into community counselling and psychological services.
- The practice held a carers register and there was a lead member of staff who worked to ensure the needs of this patient group were met.
- The practice had a named reception staff member for each patient living with dementia who was the first point of contact and liaised with staff internal and external to the practice to support patients.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	74.4%	88.8%	89.4%	Variation (negative)
Exception rate (number of exceptions).	3.5% (8)	8.8%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	74.4%	87.9%	90.2%	Variation (negative)
Exception rate (number of exceptions).	3.5% (8)	6.6%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	92.5%	83.1%	83.6%	No statistical variation
Exception rate (number of exceptions).	3.1% (3)	6.8%	6.7%	N/A

#### Any additional evidence or comments

The data above shows that the practice was below local and national averages for completion of care plans for patients experiencing poor mental health. However, exception reporting was low as the practice was working on encouraging these patients to attend.

The practice was working to improve engagement and attendance rates for patients experiencing poor mental health. The practice had bimonthly meetings with the consultant psychiatrist and monthly meetings with community mental health practitioners.

Patients were invited to care plan reviews by written and text invitations and alerts were on patient records so that staff were informed and could invite relevant patients to attend opportunistically.

#### 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)	552.1	534.0	539.2
Overall QOF score (as a percentage of maximum)	98.8%	95.5%	96.7%
Overall QOF exception reporting (all domains)	5.9%	6.6%	5.9%

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

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

<p>There was a planned audit programme for both clinical and operational audits.</p> <p>An audit took place to review treatment for diabetic patients. The outcome of this showed that two out of twelve patients were able to stop taking medication and to continue with lifestyle changes.</p> <p>A local audit to review prescribing of antibiotics for patients with urinary tract infections took place to review practice.</p> <p>The practice conducted an audit to review patients prescribed medication to reduce cholesterol. This showed that in June 2019 80% of these patients were recorded as having their target level compared with 98% in January 2020 and therefore significant improvement.</p> <p>Medication audits took place appropriately including when safety alerts were received. An example was an audit of medicines prescribed to female patients of child-bearing age. Audits of high-risk medicines were ongoing to ensure appropriate prescribing.</p> <p>Infection control audits were completed on a monthly basis.</p> <p>An audit to review the triage system and use of clinical time took place to provide a comprehensive overview of appointments and to ensure the rota met the needs of patients.</p>
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## Effective staffing

**The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.**

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:	
The practice held monthly training sessions with the whole practice team.	
The practice employed apprentices in administrative roles and provided full time employment when the staff member was qualified in their role.	

**Coordinating care and treatment**

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) <small>(QOF)</small>	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

## 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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	92.5%	94.3%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.5% (12)	0.9%	0.8%	N/A

## Consent to care and treatment

**The practice always obtained consent to care and treatment in line with legislation and guidance.**

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y

## Well-led

## Rating: Require Improvement

The rating has moved from good to requires improvement because:

- A comprehensive system was not in place for ensuring emergency drugs and equipment met requirements.

### 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 vision and 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
<p>Explanation of any answers and additional evidence:</p> <p>We saw the system to manage complaints was comprehensive and ensured appropriate action was taken and complaints followed up. Patients received timely responses to complaints which included explanations and apologies.</p> <p>Two staff members had attended mental health first aider training and provided wellbeing support to the staff group.</p> <p>Staff had access to a national Freedom to Speak Up Guardian and information about this process was outlined in the whistleblowing policy. The clinical commissioning group did not provide this role at the time of the inspection.</p>	

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

Source	Feedback
Staff feedback	<p>Staff told us there was an open and supportive culture at the practice. They were provided with time and resources for training they required and encouraged to develop their skills.</p> <p>Staff stated there was good communication across all staff groups and managers were visible and approachable.</p>

## Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:  Staff had designated lead roles with clear responsibilities and fed into the governance structure appropriately.  The practice had regular communications with Liverpool clinical commissioning group (CCG) and the primary care network. This provided opportunities to receive information from across the area.	

## Managing risks, issues and performance

**There were clear and effective processes for managing risks, issues and performance, however some improvements were required.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
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.	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
Explanation of any answers and additional evidence:  The practice manager had been in post for six weeks at the time of the inspection and was in the process of reviewing and adapting systems and processes. These reviews had been prioritised to ensure that the areas of most risk had been addressed and that plans were in place to improve other systems in the near future.  We saw that the system for ensuring emergency medicines and equipment was not robust. Although all the necessary equipment was in place as required and checks had taken place monthly, one	



medicine had an expiry date of November 2019 and another December 2019.

None of the sinks in the clinical rooms complied with best practice guidance.

The practice had systems in place to reduce risks with recruitment. However, staff recruitment files did not contain photographic identification for two out of three files reviewed.

**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

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner’s Office.	Y
Patient records were held in line with guidance and requirements.	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

Feedback from Patient Participation Group.

### Feedback

The practice had a patient participation group (PPG) with ten active members. The practice also had approximately 40 virtual members. We met with a representative from the PPG who told us the group were kept informed about changes at the practice and had been actively involved in gathering patient feedback and organising events.

### Any additional evidence

The practice conducted a patient feedback survey in December 2019 to explore views on communications, access to the building and appointments, knowledge of services provided and overall satisfaction. Results showed that 100% of the 39 patients who participated would recommend the practice and were satisfied overall.

The CQC received 45 comment cards as part of the inspection. Of these, 42 contained positive comments regarding friendly staff who listen to patients, flexible and ease of access to appointments. Three comment cards were mixed with comments about appointments sometimes feeling rushed and the wait once at the practice at times.

## 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

Examples of continuous learning and improvement
<p>The practice had developed a triage system to improve access to appointments and also used an online consultation system. Patients were therefore able to access clinicians online, by telephone and face to face appointments. The practice continued to review these processes to ensure patient demand and needs were met.</p> <p>The practice was part of a primary care network (PCN) with other local GP practices working together to improve services for patients.</p>

## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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

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

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

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

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

## Glossary of terms used in the data.

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