Democratic and Member Support
Chief Executive's Department
Plymouth City Council
Ballard House
Plymouth PL1 3BJ

Please ask for Helen Wright/Kristin Barnes
T 01752 304022/307903
E Democratic Support Officer
www.plymouth.gov.uk/democracy
Published 28/09/16

SELECT COMMITTEE REVIEW

Thursday 6 October 2016
10.00 am
Warspite Room, Council House

Members:
Councillors Mrs Aspinall, Carson, Dann, James, Dr Mahony and Tuffin.

Members are invited to attend the above meeting to consider the items of business overleaf.

This meeting will be broadcast live to the internet and will be capable of subsequent repeated viewing. By entering the Warspite Room and during the course of the meeting, Councillors are consenting to being filmed and to the use of those recordings for webcasting.

The Council is a data controller under the Data Protection Act. Data collected during this webcast will be retained in accordance with authority's published policy.

For further information on attending Council meetings and how to engage in the democratic process please follow this link - http://www.plymouth.gov.uk/accesstomeetings

Tracey Lee
Chief Executive

Select Committee Review

Agenda

1. To Appoint a Chair and Vice Chair

The Committee will be asked to appoint a Chair and Vice Chair.

2. Apologies

To receive apologies for non-attendance submitted by Members.

3. Declarations of Interest

Members will be asked to make any declarations of interest in respect of items on this agenda.

4. Chair's Urgent Business

To receive reports on business, which in the opinion of the Chair, should be brought forward for urgent consideration.

5. Select Committee Review, Proposals for GP Services in Plymouth:

5.1. Select Committee Review Plan **(Pages 1 - 2)**

5.2. Supporting Information: NHS England - GP Care in Plymouth **(Pages 3 - 20)**

6. Witnesses:

6.1. Public Health **(Pages 21 - 34)**
Area Profiles for; Devonport Surgery **(Pages 35 - 46)**
Hyde Park Surgery **(Pages 47 - 58)**
St Barnabus Surgery **(Pages 59 - 70)**
Saltash Road Surgery

6.2. Healthwatch **(Pages 71 - 113)**
Healthwatch Plymouth Report: Future GP Commissioning Patient Impact

6.3. Representatives of Patient Groups

6.4. Councillors

7. Recommendations

8. Exempt Business

Members of The Public to Note
that under the law, the Panel is entitled to consider certain items in private. Members of the public will be asked to leave the meeting when such items are discussed.

This page is intentionally left blank

SELECT COMMITTEE REVIEW PLAN

Overview and Scrutiny

SELECT COMMITTEE TOPIC

PROPOSALS FOR GP SERVICES IN PLYMOUTH

Raised by -	Councillor Mary Aspinall (Chair, Wellbeing Overview and Scrutiny Committee)
Date -	15 August 2016

Purpose of Review

The review will consider changes to the provision of General Practice in areas across Plymouth and the impact on communities within which they are located.

Rationale

The Wellbeing Overview and Scrutiny Committee may review and scrutinise any matter relating to the planning, provision and operation of the health services in its area. The committee has a number of significant powers including being able to make reports to local health bodies and referrals to the Secretary of State for Health.

Recently proposals have been developed by NHS England for the future procurement of Primary Care Services within areas of Plymouth. Both members of the scrutiny panel and the wider membership have been made aware of public concern in relation to these proposals.

The review process will review a wide range of evidence and existing research material alongside witness testimony before concluding whether or not proposals should be deemed a substantial variation of service. Following that conclusion members of the review will make a report to NHS England on their findings

During the session members will consider –

- The evidence and policy basis for the proposals
- Their assessment of how the proposals enable them to fulfil their statutory duties to address health inequalities
- How they have meaningfully engaged with patients and stakeholders, and
- How they have reflected feedback from that engagement in further development of their proposals.

Select Committee Membership
Councillors Mrs Aspinall, Carson , Dann, James, Dr Mahony andTuffin

Process	
Methodology/Approach	Single Select Committee Session to be held in the Council House with witnesses, presentation from officers and relevant paperwork.
Sources of Information/Evidence	• NHS Five Year Forward View (NHS England) • the General Practice Forward View (NHS England) • Securing the future of general practice: new models of primary care (The Kings Fund / Nuffield Trust) • The 2022 GP: A vision for General Practice in the Future NHS • Public Health Profiles for affected communities
Consultation Exercises	The Select Committee will review consultation undertaken by NHS England in relation to affected surgeries.
Witness/Expert Participation	Required under the Act • NHS England • Director of Public Health In addition – • Ward Councillors • Healthwatch • Affected Patients who may wish to speak
Site Visits	N/A
Resource Requirements	Met within existing resources.
Prioritisation	4 (Medium)

Post Review	
Reporting Process	Initial report to be made to NHS England by 12 October 2016. Further reports may be required following statutory response period.
Anticipated Completion Date	Mid – November
Draft Report Deadline	Mid – October
Meeting Frequency	Single Session
Dates of Meetings	06/10/16
Further Information	N/A

GP care in Plymouth

Paper to Wellbeing Overview and Scrutiny Select Committee

6 October 2016

This paper has been prepared by NHS England for Plymouth's Wellbeing Overview and Scrutiny Committee on proposed changes to GP care in the city.

More specifically, this paper covers options relating to:

- Barne Barton
- The Ernesettle practice, spanning Ernesettle, Mount Gould, Trelawny and Cumberland surgeries
- Hyde Park Surgery
- St Barnabas Surgery
- Saltash Road Surgery

NHS England welcomes the views of the Wellbeing Overview and Scrutiny Committee; these will be taken fully into account when decisions are taken.

Background: How GP services work

NHS England is responsible for the commissioning of primary care medical services (general practice) across England. NHS England – South (South West) is the local office that manages these contracts for the area from South Gloucestershire to the Isles of Scilly Plymouth. There are around 500 practices.

The general practices themselves are independent businesses, operating under contracts with NHS England. This means that, in return for providing specified services, they are paid for each patient on their books.

All contract-holders employ their own staff and provide their own premises. Some own their buildings and some rent them; either way, premises costs are reimbursed by NHS England.

The relationship is based on three broad types of contract:

- GMS (General Medical Services) – the standard, indefinite national contract

- PMS (Personal Medical Services) – locally-negotiated indefinite contracts, usually dating back to before the last NHS reorganisation
- APMS (Alternative Provider Medial Services) - locally-negotiated, time-limited contracts (now a maximum of five years, plus potential extension of two years)

Following review in 2015 to regularise payments across PMS and GMS contracts that have grown up over the years, these practices are all now paid a basic population-weighted annual rate of £76.44 per patient. Previously practices had been paid differing amounts, often for the same level of service.

The standard services that practices provide are set out in appendix 1. Appendix 2 is an illustrative example of practice costs and income, based on a list size of 3,000 patients. This highlights that practices can provide additional services to increase their income, though this will of course also increase staffing requirements and other costs.

NHS England has a duty to ensure that people have access to primary care. This duty is therefore exercised in an environment where providers may resign their contracts at any time and where nobody is under any obligation to take up a new contract; these are entirely business decisions by existing and potential providers.

This means there is a very big difference between actively seeking to close a service and facing the realities in trying to keep it open.

General practices in Plymouth

In Plymouth today, there are 37 separate contracts with independent providers for general medical services. All of these providers except Ernesettle, Hyde Park and St Barnabas have either GMS or PMS contracts, held in perpetuity. This means NHS England is not in a position to directly reorganise primary care services, unless there is either a contract closure or a contract resignation.

Since NHS England was formed in April 2013 there have been three mergers of practices in Plymouth. Some practices are signatories to each other's contract so, while not technically merging, these work more closely together.

There has also been significant investment in upgrading primary care facilities in Plymouth to meet the needs of patients in the 21st century. Devonport Health Centre, St Neots Surgery, Wycliffe Surgery, Ernesettle Primary Care Centre and Mount Gould Primary Care Centre are all examples of improvement and investment to expand the premises to accommodate more patients and the clinical teams to provide the care.

The current position

Over the past year, a number of independent contractors have decided to resign their contracts to provide primary care in Plymouth, handing over responsibility for their patients to NHS England:

- Livewell South West, a community-interest company, handed back its APMS contract when it came to an end for Ernesettle Practice and did not want to pursue any contract extension. Alongside Ernesettle, Livewell had branches at Mount Gould, Trelawny and the Cumberland Centre. The latter surgery – in the same building as the Minor Injuries Unit and other services – was never commissioned by the NHS, but set up 'at risk' by Livewell.

- Dr Jonathan Gale resigned his contract at St Barnabas Surgery. As a single-handed GP, only three months' notice was required. This was a GMS contract. As such, Dr Gale had the option to bring in new signatories or to merge with other surgeries in order to keep the contract going. Dr Gale had explored various options to continue the practice, but without success.

- Dr Stephen Warren and Dr Juliette Whitfield resigned their contract at Hyde Park Surgery. This was a PMS contract. As such, the partners had the option to bring in new signatories or to merge with other surgeries in order to keep the contract going. The GPs had explored various options to continue the practice, but without success.

- More recently, Dr Robert Gardner has resigned his single-handed contract at Saltash Road Surgery. This was a GMS contract. As such, Dr Gardner had the option to bring in new signatories or to merge with other surgeries in order to keep the contract going. Dr Gardner had explored various options to continue the practice, but without success.

Using a procurement framework of approved providers, NHS England was able to secure the services at all these sites for a time-limited period, so options for the future could be considered. This inevitably attracts a significant financial premium, given the rapid mobilisation required and short-term nature of the agreements.

A similar process has also been in place with a practice in the Rame Peninsula, following resignation of the single-handed GP. In the light of engagement work with patients, NHS England decided to procure a new provider. This was unsuccessful, with no bids received. Patients have now re-registered with other practices, while work continues with the local community and with the neighbouring practice to re-open the previous premises at Millbrook.

This picture is becoming increasingly familiar in the South West, as workload and financial pressure increases. The short-term contracts in Plymouth, with Access Healthcare, have therefore been aligned to end together on 31 March 2017. This was designed to allow for NHS England to take a wider look at primary care in Plymouth, so steps could be taken to make the system of GP care more sustainable for the longer term, in line with the General Practice Forward View (see below).

This strategy also ties in with the procurement of a new service for the people of Barne Barton, a deprived area of Plymouth that does not currently have its own surgery.

It is therefore important that the proposals for Plymouth are seen as a whole. The series of contract handbacks provides a rare opportunity for NHS England and Northern, Eastern and Western Devon Clinical Commissioning Group to take a more-strategic look at primary care in Plymouth, given limited ability to make change with a system of indefinite contracts.

The evidence and policy basis for the proposals

Pressure on general practices

Ninety pet cent of contacts with the NHS are through primary care, so it is essential that we have a high-quality, accessible 'front door' if we are to manage the pressures facing the NHS as a whole.

However, general practice is under increasing pressure both locally and nationally. This is caused by a number of factors:

- Increasing demand – between 1995 and 2008 the average consultation rate per patient rose from 3.9 appointments per annum to 5.5 appointments per annum. Consultation rates have continued to rise and a 2015 national study by the Nuffield Trust indicates that the average rate is now likely to be approaching 8 consultations each year.
- Increasing complexity - While the total number of people with one or more long-term condition is expected to remain stable over the next 10 years, the number with two or more long-term conditions is projected to increase, from 5 million today in England to about 6.5 million.
- Alongside long-term conditions, the prevalence and complexity of disease increases with age. The number of those aged over 80 years is expected to double between 2010 and 2030. Older patients aged over 80 years consult more frequently – between 12 and 14 times a year in 2008/09.
- The increases in workload have not been matched by increased investment in primary care or numbers of GPs. Across England expenditure on primary care as a proportion of total health spending has been reducing and whilst there has been an 18% increase in the number of GP's over the last decade this is not sufficient to meet the increased workload.
- Recruitment of both GPs and primary care nurses is an increasing challenge, with vacancies in training places together with increased proportions of GPs wishing to work part-time or to have a 'portfolio' career. The traditional partnership model for general practice is also changing with more doctors wishing to be employed by the practice rather than become a partner in the business, with its attendant risks and pressures. Smaller practices are finding it particularly hard to recruit.
- Primary care has been changing the way it works in response to those pressures, with most GP practices now employing a wider range of health professionals to see and treat patients, including nurses with increasing levels of specialist expertise, pharmacists and therapists.
- Many practices are also encouraging different forms of access to complement the traditional face-to-face appointments, such as telephone or on-line advice, triage or consultations.

The GP Forward View: nationally and locally
The blueprint for NHS England in the South West, as in the rest of the NHS, is the General Practice Forward View (April 2016).

The GP Forward View will see an increase of £2.4 billion invested in primary care over the five-year period to 2020/21. This is a 14% real-terms increase in spending on primary care.

In addition there is a £500m 'sustainability and transformation' package to support that investment, including plans for significant numbers of extra GPs and other health professionals, and help and support to change the way in which services are organised so that the increasing workload can be managed.

The key changes envisaged in the GP Forward View are designed to address the following issues:

- **Workforce:** including specific commitments to provide more doctors, physician assistants, clinical pharmacists and mental health therapists so that patients will have access to a wider range of clinical expertise via their GP practice. Patients will also be encouraged to make greater use of pharmacies for advice and treatment of minor ailments.
- **Workload:** enabling practices to participate in the national 'Making Time for Patients programme' and to implement 10 High Impact Changes. There is also training for administrative staff to enable them to support GPs better by signposting patients to the right service and to deal with some clinical paperwork. There is also a £40 million resilience fund to support practices to work together and ensure there is a sustainable model of primary care which can meet the changing and increasing demands on general practice.
- **Infrastructure:** a £900 million investment programme to support increased use of technology and invest in building which will support the new service model which is developing.
- **Care redesign:** the Government is committed to developing extended access to general practice so that patients can access services seven days a week. This development needs to be integrated with changes to NHS 111 and out-of-hours services so that patients are supported to access care locally where ever clinically appropriate.

NHS England in the South West has also put in place a local Primary Care Development Fund package of support, with a particular emphasis on identifying and supporting those practices that are potentially vulnerable and on encouraging practices to work together in order to create sustainable delivery models.

This work has being supported by the appointment of a change manager in each CCG area, together with region-wide project co-ordination and support. New streams of funding and support including the resilience and access funds will build on this approach to help implement locally-appropriate solutions.

Taken together, the investment and change in primary care will mean a sustainable model of service delivery can be developed across Plymouth. It is, however, also likely that patients

will access services in different ways and be seen by a wider range of staff; WOSC members will have an important role in working with NHS England and the CCG to help to plan and communicate local changes in a positive way to patients and the public.

In order to celebrate the many good examples of change and innovation already being implemented across the region which demonstrates the GP Forward View vision in action NHS England is running a conference and awards event in October. This will enable practices to learn from colleagues locally and to be supported by practical tool to help them implement changes available on a new web-site being developed in conjunction with the Academic Health Science Network.

This overall approach means that, when commissioning care in Plymouth, NHS England's emphasis must be on:

- Developing GP services at a scale that can cope with the financial and work pressures; otherwise there is a greatly-increased risk that providers will find their businesses unviable and that patients will be left without a practice
- Encouraging innovative and extended services that offer maximum benefits for patients
- Making best use of capacity and of good buildings that already exist
- Making best and fairest use of taxpayers' money
- Tackling inequalities

GP services in the longer term: the process

With temporary contracts in place from the first part of 2016, NHS England was able to begin looking at options for the longer term, taking into account key factors including:

- National policy (see below)
- Population profiles, including levels of deprivation
- Geographical spread of patients registered with each practice
- Capacity in other practices
- Accessibility
- Sustainability of services
- Value for money

As a result, NHS England wrote to patients at Ernesettle, Mount Gould, Trelawny, Cumberland, St Barnabas and Hyde Park in August 2016 to share our early thinking regarding the options that we were considering for each surgery so that we could commence patient engagement.

This viewpoint has been used as the basis for intensive engagement work with patients at each surgery, so patients could understand the position from NHS England's perspective and, most importantly, NHS England could find out what they thought.

In the case of Ernesettle, Mount Gould and Trelawny, where the likely option was to reprocure, this was primarily to help shape the service specification that would be put to bidders.

In the case of St Barnabas, Hyde Park and Cumberland, the aim was to find out what impact loss of their surgery might have and to explore any other viable options. A similar approach is also now under way for Saltash Road surgery, following the subsequent resignation of the contract-holder.

Only when all feedback has been received and analysed will any decisions be taken by NHS England. This should be in October 2016.

This timescale is designed to enable any other surgeries to be added to the procurement process, or other options to be pursued, while still allowing time for all changes to be put into place by 1 April 2017.

The options for practices in Plymouth

The options for practices in Plymouth, as shared with patients, have been developed by NHS England with the Northern, Eastern and Western Devon Clinical Commissioning Group (which will be taking on greater responsibility for commissioning primary care) and with input from local GPs and from Devon Local Medical Committee.

Healthwatch Plymouth, Plymouth City Council and a GP are also represented on the group that has overseen this work.

The proposals can be broken into three:

1 Barne Barton
Efforts have been under way since 2007 to enhance the provision of GP care, alongside other community-based health and social care services. Work has been carried out to identify the specific needs of the population, and possible responses to meet those needs.

The case for procurement is based on multiple factors:

- High levels of deprivation
- Its designation as a top-priority neighbourhood within the Neighbourhood Renewal Action Plan (and one of only three to be sufficiently deprived to receive Government Neighbourhood Renewal Funding)
- An increasing population, currently around 5,000
- A clear wish from the community for such a development
- A high proportion of children
- Geographical and social isolation, with access via only one road.
- Community commitment to creating premises alongside the Tamar View Community Centre

Although a procurement exercise in 2015 failed to attract bidders, it is included in the wider procurement in 2016 because offering the contract alongside others will make it more attractive, potentially as part of a bigger bid (GP care 'at scale').

Consideration will also be given to the setting up of temporary premises, to enable the new service to start work pending the creation of permanent accommodation.

2 Ernesettle, Mount Gould, Trelawny and Cumberland

For historical reasons, although a single practice, this is the most-complicated arrangement. The four surgeries were previously run by Livewell SouthWest (formerly known as Plymouth Community Health), under a time-limited APMS contract. This expired at the end of March 2016. LiveWell decided against pursuing the option of a contract extension.

Although Livewell SouthWest ran the practice from four sites, only Ernesettle, Mount Gould and Trelawny were commissioned by the NHS. Cumberland had been set up on its own initiative ('at risk') by Livewell SouthWest.

Since then, the brand-new Devonport Health Centre has been built just across the car park from the Cumberland Centre. This modern building was created for a registered population of more than 9,000 patients; it currently has around 5,600.

When the new short-term provider, Access Healthcare, was appointed in 2016, NHS England decided to include the Cumberland in order to avoid any immediate disruption for patients.

The position is further complicated by the fact that the Cumberland premises are within the bigger Cumberland Centre, which also houses a minor injuries unit and other community services, which are commissioned by the CCG.

The CCG and Plymouth City Council are currently considering the best model for health and wellbeing hubs as part of their long-term vision for health and wellbeing. This could include Cumberland.

The CCG also commissions its GP outreach service for homeless people from Access Healthcare; although the GP who leads this work is based at the Cumberland, this is an administrative centre, with clinical care provided in the community. This CCG aims to continue commissioning an outreach service after the current contract ends, also on 31 March 2017.

NHS England has therefore set in motion a process to procure GP services for Ernesettle, Mount Gould and Trelawny – the three surgeries previously commissioned. NHS England has been talking with patients who use the three surgeries and running a survey, to inform the service specification (see below).

Bids have been received in the initial stage of the procurement process, based on a generalised specification. Once all patient feedback has been received, final specifications

will be drawn up and the second phase of procurement launched. This process is subject to modification if the decision is to include any other surgeries.

At the same time, NHS England has been exploring the option that Cumberland Surgery, which was never commissioned by the NHS, should not be re-provided when the current contract ends and what arrangements would need to be in place to sustain access to good GP services. This is because:

- The GP premises within the Cumberland Centre are inadequate (two windowless consulting rooms); this issue has been raised with NHS England by staff
- The surgery serves relatively few registered patients (around 1,800)
- Both of these factors would make the surgery unattractive to potential eligible bidders
- Everyone who goes to the surgery is registered with the single Ernesettle practice, so would, as now, be able to use any of the other three surgeries without re-registering
- Anyone who uses the surgery would alternatively be able to re-register with the new, purpose-built Devonport Health Centre on the same site
- Other practices in the area are also willing and able to take extra patients, so nobody need be left without a doctor
- There are real benefits in being part of a larger practice, with greater choice of appointments, more services and a wider range of skilled staff

3 St Barnabas, Hyde Park and Saltash Road

Based on the need to support sustainable general practice, as set out in the GP Forward View, NHS England has been engaging with patients on the option not to re-procure services at St Barnabas and Hyde Park. The same approach is now being taken for Saltash Road.

This is because:

- Their viability was already in doubt, given that all contracts were handed back to NHS England by the previous contract-holders, who were unable to secure the practices' future either by bringing in new signatories or by merging with other surgeries
- All are relatively small, which makes it harder for the practices to survive at a time when GP care is under pressure and it is hard to recruit staff – especially doctors
- Other practices in the area are willing and able to take extra patients, so nobody would be left without a doctor
- There are real benefits for patients in being part of a larger practice, with greater choice of appointments, more services and a wider range of skilled staff

As a result, NHS England's experience suggests that it would be difficult to find any willing and eligible provider interested in bidding for the three surgeries at the standard rate of £76.44 per patient – markedly lower than the value under the current, temporary contract. Given these factors, NHS England's preliminary view is that the best way forward and best use of taxpayers' money would be for these surgeries to close and to make use of capacity at other practices in the area.

The income flowing to those other practices would also improve their viability.

How decisions will reflect statutory duties to address health inequalities

As NHS England reviews the sites and options for the future, a foundation of the work will be Health Equality Impact Assessments on all sites using the approved and recently-updated NHS England templates. Expert advice has also been sought from NHS England's central team to promote health equalities in line with recent legislation (Health and Social Care Act 2012). These will be reviewed in the light of patient engagement.

NHS England commissions general medical services for people who are ill or believe themselves to be ill. Our commissioning colleagues in the clinical commissioning group and within public health at the city council also commission a range of local enhanced services from GPs to meet the specific needs of the local population.

Therefore, when undertaking any health equality impact assessment, NHS England is conscious of the fact that patients have access to several other GP surgeries that are commissioned to provide the same services.

The impact of a potential closure would be mitigated by access to other practices nearby, all of which have open lists and can register new patients.

Overall, when considering the options on whether or not to seek new providers for St Barnabas, Hyde Park, Cumberland and Saltash Road, NHS England will take into account:

- Feedback from patients
- Population profiles, including levels of deprivation
- Where patients live
- Equality Impact Assessments
- Transport issues, including bus routes
- Accessibility issues, including provision for people with disabilities

How we have engaged with patients and stakeholders

NHS England guidance on engagement is set out in its 'Statement of Arrangements and Guidance on Patient and Public Participation in Commissioning' (December 2015).

This extract explains duties under Section 13Q of the Health and Social Care Act 2012 and includes an important example:

> Where public involvement is required, NHS England has a broad discretion as to *how* it involves the public. However, this is not an absolute discretion: it must ensure that its arrangements are ***fair*** and ***proportionate***.
>
> ***Fair***
> The courts have established guiding principles for what constitutes a fair consultation exercise. These principles (known as the *Gunning* principles) were

developed by the courts within the context of what constitutes a fair *consultation* and will not apply to every type of public involvement activity. However, they will still be informative when making plans to involve the public.

The *Gunning* principles are that the consultation:

- Takes place at a time when proposals are still at a formative stage. If involvement is to be meaningful, it should take place typically at an early stage. However, it is often permissible to consult on a preferred option or decision in principle, so long as there is a genuine opportunity for the public to influence the final decision.
- Gives the public sufficient information and reasons for any proposal to allow the public to consider and respond.
- Allow adequate time for the public to consider and respond before a final decision is made.
- The product of the public involvement exercise must be conscientiously taken into account in making a final decision.

Proportionate

It is almost always possible to suggest that more can be done or that an exercise can be improved upon, particularly with hindsight. However, NHS England needs to balance its duty to make arrangements to involve the public with its duty to act effectively, efficiently and economically. Therefore, the arrangements for public involvement and activities flowing from those arrangements need to be proportionate.

NHS England should also consider the potential impact on other services, which may not be commissioned by NHS England (e.g. ambulance services), and issues for patients beyond the clinical services themselves such as accessibility, transport links and ambulance availability.

For example:
A small GP practice in an urban area is likely to close due to the retirement of the lead partner and difficulties relating to the condition of the practice premises. The patient list can be dispersed to a neighbouring GP practice two streets away. The public involvement duty would be engaged, but carrying out an extensive public involvement exercise in relation to the changes may be disproportionate. Local commissioners arrange to write directly to all current patients of the practice informing them of the planned change, and ensure that clear notices are displayed on noticeboards at the surgery and local community venues, and that information is included on the practice website. They talk to the patient participation groups of both surgeries about the impact of the proposed changes and arrange a drop-in session at the practice for patients to find out more. Specific efforts are made to reach those who may be easy to overlook, including seeking advice from the local community and voluntary services about the impact on groups in the local community that experience the greatest inequalities.

When considering the way forward for all affected practices in Plymouth, NHS England was very clear that options should not be closed off for those surgeries that, in its preliminary view, should not be procured. The decision-making process was timetabled so any of these surgeries could still be added into the procurement process, to try and find a new provider for 1 April 2017.

The process is being overseen by a group that includes representatives NEW Devon CCG, Plymouth City Council and Healthwatch Plymouth, along with an independent GP. Devon Local Medical Committee and other GPs also helped shape the proposals.

The approach to direct patient engagement has been two-fold:

1. For Ernesettle, Mount Gould and Trelawny patients, a survey was set up so they could consider issues such as opening hours, types of staff and levels of service. The online survey ran until Friday 23 September, supplemented by paper copies that were available from the surgeries. Results are now being analysed so service specifications can be finalised for phase two of procurement. Considerable, similar feedback had already been gathered from people in Barne Barton, as part of the abortive procurement process in 2015.

2. For St Barnabas, Hyde Park and Cumberland the brief was to try to understand what impact the loss of their surgery would have on individual patients and if there might be any other viable options than closure and dispersal of the registered list. The same approach is now under way for Saltash Road (see below)

Initial contact with patients was via letter sent week commencing 22 August. These letters had been due to go out a week earlier, but were held up at NHS England's national contractor.

A series of drop-in sessions were organised for interested patients. The initial round was referred to in the patient letters, with explicit acknowledgement that these slots would not suit everybody and with an open invitation to suggest further, convenient dates via email or phone.

Given that the first date was very close to the time when letters would arrive, Patient Participation Groups were briefed the week beforehand and asked to spread the word. In the event, the initial drop-in sessions were very well-attended, overrunning their timeslots.

While awaiting suggestions of further dates, further rounds were proactively arranged at different times of day, and publicised via Patient Participation Groups and other stakeholders. Many of these were also well-attended.

There was some confusion over format among patients at the first three sessions. This was addressed for subsequent events by the addition of a 'meet and greet' member of staff to explain the process.

This process involved small-scale discussions with NHS England staff, supported by Healthwatch Plymouth. This allowed individuals to discuss their personal positions, in private if necessary. The impact of potential closure was captured in feedback forms that had been developed with Healthwatch Plymouth.

These forms were also sent out and returned electronically.

Public meetings were not held. Long experience has shown that these are ineffective in capturing the type of feedback that was needed by NHS England, which centres on individual experience. Many patients would not attend an open meeting, or would not speak up in such an environment; these are often the people from whom NHS England would not otherwise hear.

The full programme of drop-in sessions was:

Hyde Park Surgery	Thursday 25th August	10.00am
St Barnabas Surgery	Thursday 25th August	12.00pm
Cumberland Centre Surgery	Thursday 25th August	2.00pm
St Barnabas Surgery	Tuesday 30th August	4.30pm
Cumberland Centre Surgery	Wednesday 31st August	4.30pm
Hyde Park Surgery	Friday 2nd September	4.30pm
Ernesettle Primary Care Centre	Thursday 8th September	10.00am
Trelawny Surgery	Thursday 8th September	12.00pm
Mount Gould Primary Care Centre	Thursday 8th September	2.00pm
Cumberland Centre Surgery	Monday 12th September	10.00am
St Barnabas Surgery	Monday 12th September	12.00pm
Hyde Park Surgery	Monday 12th September	2.00pm
Mount Gould Primary Care Centre	Monday 19th September	10.00am
Ernesettle Primary Care Centre	Monday 19th September	12.00pm
Trelawny Surgery	Monday 19th September	2.00pm

As well as being briefed by NHS England the week before the letters were sent, Patient Participation Groups were asked to help generate interest, to advise on any particular hard-to-reach groups, and to distribute the feedback forms.

As of 23 September, well over 300 feedback forms had been received, along with other comments via email, phone and post. These are being analysed, so the key issues can be identified and taken into account in the decision-making process.

The feedback and comments are being collated under four main themes:

- Relationship with another practice
- Access to another practice
- Re-location (travel, access)
- The services available at another practice

Healthwatch Plymouth has also been gathering patient feedback via its own online system. This is being collated in its own report.

As stated above, the approach to Saltash Road has been the same as for Hyde Park, St Barnabas and Cumberland. NHS England is now seeking to find out what impact the loss of their surgery would have on individual patients and if there might be any other viable options other than closure and dispersal of the registered list.

Patient feedback forms are available online and via the surgery, while initial drop-in sessions are planned for 12 October.

How feedback from engagement will be reflected in further development of proposals

The results of the engagement and feedback from patients and Healthwatch, together with the outcome of this Select Committee, will feed into the decision-making process, which has been put back to enable all input to be collected.

Options for all of the sites will form a paper recommending the way forward for consideration by the directors of NHS England South West. The decisions are needed by later October in order to meet the timescales for making necessary changes by 1 April 2017.

The options and recommendations for St Barnabas, Hyde Park, Cumberland and Saltash Road will give full weight to patient feedback, alongside all other factors outlined above. This allows for any of these surgeries to be placed into the procurement process, or for other options to be followed through.

If the decision is taken to disperse any patient lists, the timescale also allows for this to be managed, so that the patient experience is as smooth as possible in transferring to other GP practices. NHS England always requires a detailed exit plan from provider in these circumstances, with special attention to the needs of vulnerable people.

The options and recommendations will also span Ernesettle, Trelawny, Mount Gould and Barne Barton. While initial bids have been received, the next phase will see a full specification circulated, drawing on patient feedback. Bidders will need to satisfy NHS England that they can provide a safe and effective service against this specification.

There is no guarantee that any of these services can be reprocured. In that case, alternative plans would need to be developed, in line with NHNS England’s duty to ensure that patients would not be without GP care.

The procurement process has built into it the opportunity for stakeholders such as the NEW Devon CCG and HealthWatch to evaluate the bids and to be involved with the decision-making process for awarding the contracts.

Range of primary care services for patients at Plymouth practices

The current contract between NHS England and all the Plymouth practices involved covers essential primary care medical services that are for people who are ill or believe themselves to be ill. This also includes treatment and care for long-term conditions.

They are also contracted to provide additional services such as basic contraception as well as childhood immunisation and vaccination programmes, plus some minor surgery. There are a number of Directed Enhanced Services which NHS England offer practices each year which include: Learning Disabilities Health Checks, Minor Surgery, Extended Access Hours and Avoiding Unplanned Admissions.

All of these services are provided at GP practices in Plymouth, therefore if these sites were to close, the affected patients could access all these services at any of the other 30 or so practices in Plymouth.

In addition to the basic primary care services that NHS England commissions the NEW Devon CCG also commission a range of services for patients and they would need to consider how best to commission those services going forward, however many of these services are commissioned annually therefore it would be possible to re provide those services elsewhere.

Similarly Plymouth City Council commissions sexual health services from GP practices including the long acting reversible contraceptives and other public health services and they too offer these on an annual basis so the provision can be changed. It is fair to summarise that most of the services commissioned by both the NEW Devon CCG and Plymouth City Council will be offered to all GP practices in the city and so there should be universal access to all the services.

The Outreach service for the homeless that the CCG currently commissions was originally procured to be run form the Ernesettle group of practices, which at that time consisted of Ernesettle Primary Care Centre, Mount Gould Primary Care Centre and Trelawny Surgery. The CCG is currently in the process of reprocuring this service. The CCG and Plymouth City Council are also currently considering the best model for health and wellbeing hubs as part of their long-term vision for health and wellbeing. This could include the Cumberland campus site

The Medical School works with practices to provide training placements for GP's and all of the six sites involved in this project are involved to a greater or lesser extent, although the provision of GP training is not contractual. NHS England has made contact with the Medical School to update them on the current process and will continue to work with them as the procurement progresses.

To summarise, all of the current services can and would be available to patients wherever they are registered, so there would be no loss of service to patients.

Appendix 1: Services commissioned by NHS England under GMS, PMS and APMS contracts

Standard contractual services:

- Minor surgery
- Learning Disability health check scheme
- Extended hours
- Avoiding Unplanned Admissions
- MMR vaccinations
- Men B
- Men ACWY
- Meningococcal Booster
- Hep B
- Rotavirus vaccinations for children
- Seasonal Flu Vaccination
- Seasonal Pneumo Vaccinations
- Childhood Seasonal Influenza (2 & 3 year olds)
- Shingles vaccinations
- Pertussis vaccinations for pregnant women
- Pneumococcal

Additional services also provided:

- Cervical screening
- Contraception services
- Vaccination and immunizations
- Childhood Vaccination and immunizations
- Child Health Surveillance
- Maternity medical services – excluding intra partum care
- Minor Surgery (curettage & cautery)

Appendix 2: Practice ready reckoner (Excel file)

Standard Practice Costing:

Appendix 2:

Practice needs to be open 8 -6.30.

Direct Costs:				Net Unit Costs £	Pluss On Costs 0.25	Gross Costs		£
Practice manager		1	Assume can manage with just one position but holidays etc covered by GP . Receptionist etc	30,000	7,500	37,500	HR/Staff, Rotas, GP business, Accounts, QoF, LES claiming, attending locality meetings etc., Premises and maintenance, CQC requirements, SEA/clinical governance meetings etc	37,500
Admin Assistant		1		20,000	5,000	25,000	Letters of referral, Scanning, actioning hospital letters, additions and deletions, coding & summarising, phone calls to chase, immunisations & screening appointments and returns.	25,000
Prescription Clerk		1	Prescriptions etc	20,000	5,000	25,000	Generate routine, acute and repeat prescriptions, Oxygen appliances, liaise with chemists, drug monitoring and relevant searches	25,000
								0
Receptionist		1	Senior Receptionist	20,000	5,000	25,000	Man reception desk, take calls, list visits, answer queries. Sort records/notes, check routine call lists eg screening.	25,000
		1	Junior Receptionist	15,000	3,750	18,750		18,750
		1	Admin/Registrations	15,000	3,750	18,750		18,750
Practice Nurse		1.3	Assume need at least 1.3wte to cover holidays , sick training etc	31,383	7,846	39,229	Chronic disease management, travel vacs,. Dressings, leg ulcers, cervical smears, contraception, weight management, immunisations, ear syringing etc	50,997
HCA		1.3	Assume need at least 1.3wte to cover holidays , sick training etc	15,000	3,750	18,750	BPs, ECGs, weight loss. Smoking cessation, simple dressings. Simple injections.	24,375
Sundry running costs			NHSE pay pass through costs re rent, rates and clinical waste but practice responsible for utilities, cleaning, maintenance, trade wates, accountancy, payroll, HR, insurance etc				Say £20,000 per annum	20,000
								157,872
Practice Income:		3,000						
Contract sum		76.44						229,320
Additional income:								
QoF	say	13.00						39,000
DES	say	6.50						19,500
LES and PH	say	30.00						90,000
	Total	125.94						377,820
Income less Direct Costs:								219,948
Gp costs		2	Say £85k per GP plus 25% on costs equals £106,000. Assume that GP can look after 2000 patients for 40 weeks per year. Thus 3,000 needs 2wte	85,000	21,250	106,250	(Nb if GP works 40 weeks then that is equivalent of 2,000/52*40 ie 1,538 patients)	212,500
			Locum to cover holidays etc and				say	20,000
							Loss	**-12,552**
							At income of £105.94 need additional patients to breakeven	-118

This page is intentionally left blank

AREA PROFILE: DEVONPORT NEIGHBOURHOOD

Author: Public Health, Plymouth City Council

Date: July 2014

This profile is produced as part of Plymouth's Joint Strategic Needs Assessment.

This profile is intended to provide a summary of the key health and social care indicators in the area. It is anticipated that the profiles will be of use to anyone with an interest in the area and how it compares with the city as a whole. Updated versions of the profiles will be produced as new information becomes available and in response to requests for additional data items or categories.

Contents

1.	Area summary	1
2.	Area table	2
3.	Area maps	3
4.	Demography	4
5.	Deprivation	5
6.	Benefits uptake	6
7.	Crime	7
8.	Education and children	8
9.	Health	9
10.	Housing	10
11.	Social care	11
		12

1. Area summary

Devonport had a total population of 6,344 in 2013. Of these 51.6% were male and 48.4% were female. 9.0% of the population were aged 0-4 years and 1.3% were aged 85+.

The overall IMD2010 deprivation score for Devonport is 60.0. Devonport ranks at number 1 (where 1 is the most deprived and 39 is the least deprived of the city's neighbourhoods).

23.4% of the population were claiming some form of benefit in 2013. This is above the city-wide figure of 11.0%. 10.9% of the working age population were claiming jobseekers allowance in 2013. This is above the city-wide figure of 3.7%.

The rate of anti-social behaviour was 79.1 per 1,000 population in 2012-13. This is above the city-wide figure of 39.5. The rate of all crime was 119.6 per 1,000 population in 2012-13. This is above the city-wide figure of 72.4.

The rate of children in need is 1,545.8 per 10,000 population aged 0-17 in 2012-13. This is above the city-wide figure of 766.3. 48.2% of pupils achieved five or more A*-C grades at GCSE (including English and Maths) in 2012-13. This is below the city-wide figure of 61.1%.

Life expectancy in 2010-12 was 73.6 years. This is below the city-wide figure of 80.5 years. The rate of emergency hospital admissions was 1,232.5 per 10,000 population in 2012/13. This is above the city-wide figure of 875.2. The all age, all cause mortality rate was 83.3 per 10,000 population in 2012. This is above the city-wide figure of 57.3.

31.0% of the private sector housing stock was classed as 'non-decent homes' in 2010. This is below the city-wide figure of 33.3%. 8.2% of the private sector housing stock was not in a reasonable state of repair in 2010. This is below the city-wide figure of 11.1%.

The rate of all clients in receipt of packages of care was 460.5 per 10,000 population aged 18+ in 2012-13. This is above the city-wide figure of 354.5. The rate of dementia clients was 58.9 per 10,000 population aged 18+ in 2012-13. This is above the city-wide figure of 43.0. The rate of clients with a learning disability was 53.2 per 10,000 population aged 18-64 in 2012-13. This is below the city-wide figure of 54.3.

2. Area table

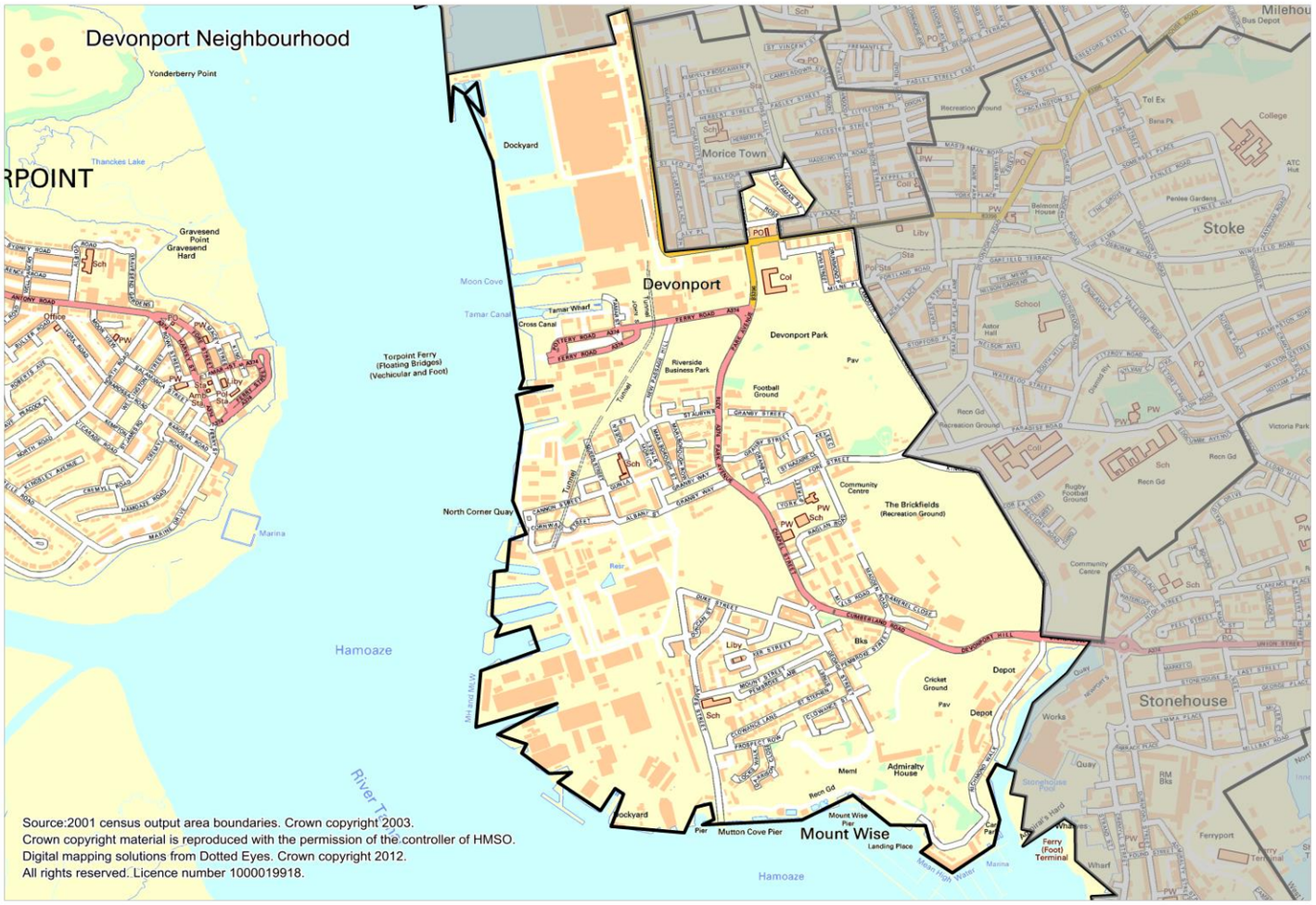
Category	Indicator	RAG
Deprivation	Overall IMD score	
	Barriers to housing and services score	
	Crime and disorder score	
	Education skills and training score	
	Employment score	
	Health deprivation and disability score	
	Income score	
	Living environment score	
Benefits uptake	Claimants	
	Jobseekers	
	Employment and support allowance / incapacity benefit	
	Lone parent	
	Carer benefit	
	Income related	
	Disabled	
	Bereaved	
	Male - employment benefits	
	Female - employment benefits	
	16-24 employment benefits	
	25-49 employment benefits	
	50 and over employment benefits	
Crime	Anti-social behaviour	
	Criminal damage	
	Domestic abuse incidents	
	Serious acquisitive crime	
	Violence with injury	
	All crime	
Education and children	Child protection	
	Children in care	
	Children in need	
	Key stage 2 pupils who achieved required Level 4 in English and Maths	
	Key stage 2 pupils with free school meal eligibility who achieved required Level 4 in English and Maths	
	Permanent exclusions	
	Pupils achieving five or more A*-C grades at GCSE (including English and Maths)	

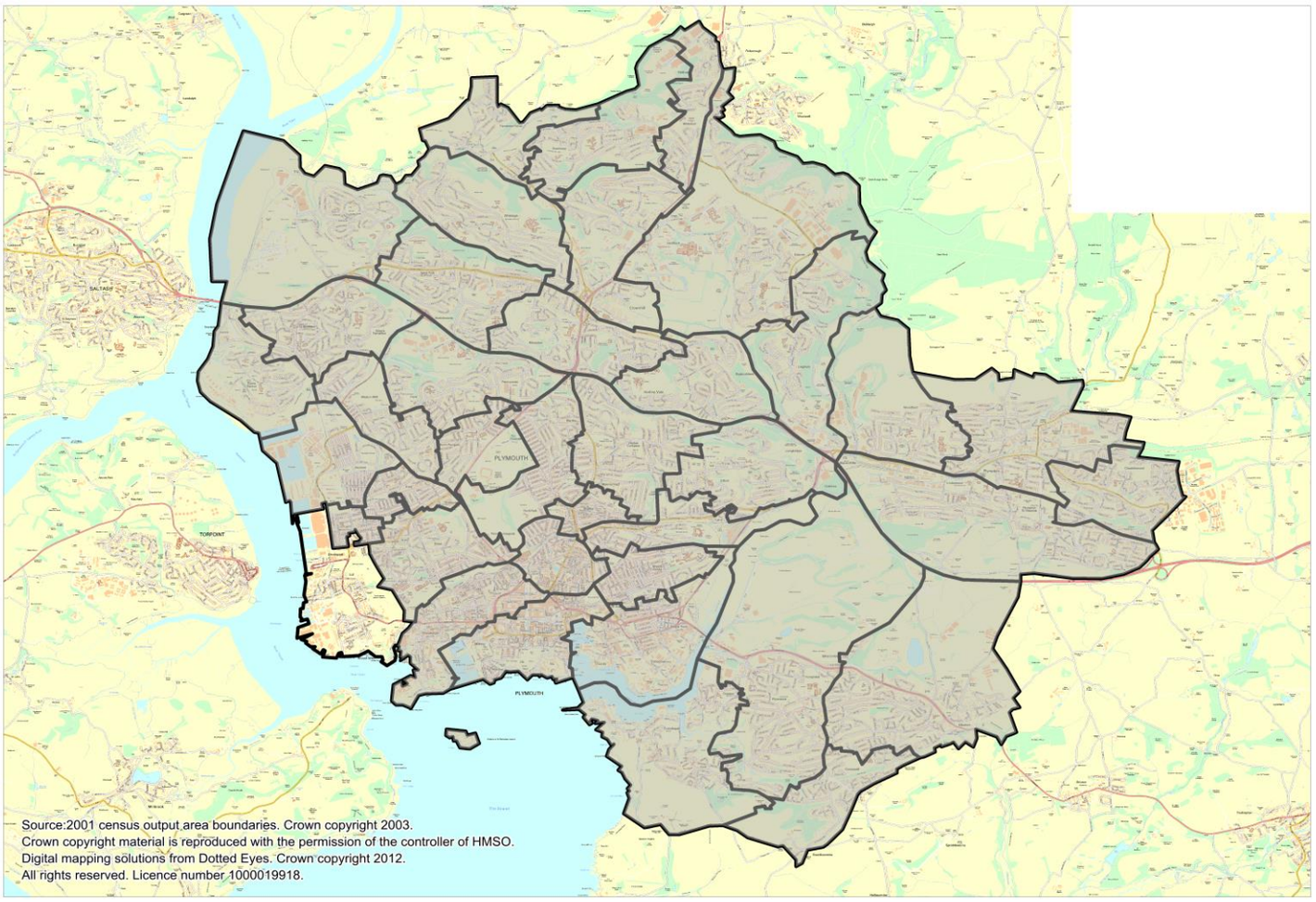
Category	Indicator	RAG
Health	Life expectancy	
	Smoking in pregnancy	
	Breastfeeding at 6-8 weeks	
	Vulnerable families	
	Excess weight (reception)	
	Excess weight (year 6)	
	Adult smoking	
	Excess weight in adults	
	Outpatient DNAs	
	Emergency hospital admissions	
	Cancer mortality <75s	
	CVD mortality <75s	
	All age all cause mortality	
Housing	Non-decent homes	
	Thermal comfort	
	Category 1 hazards	
	Disrepair	
	Non-modern amenities	
	Category 1 excess cold	
Social care	All clients	
	Community based service clients	
	Dementia clients	
	Learning disabilities 18-64 clients	

Key	
Better than Plymouth	
Same as Plymouth	
Worse than Plymouth	
Data has been supressed	N/A

Please note that the Red/Amber/Green rating applied in this table simply indicates whether the value for the area is worse, equal to, or better than Plymouth as a whole. It gives no indication of how much 'better' or 'worse' the area is than the city as a whole for that specific indicator. The definitions of each of these indicators are given on the subsequent topic-specific pages.

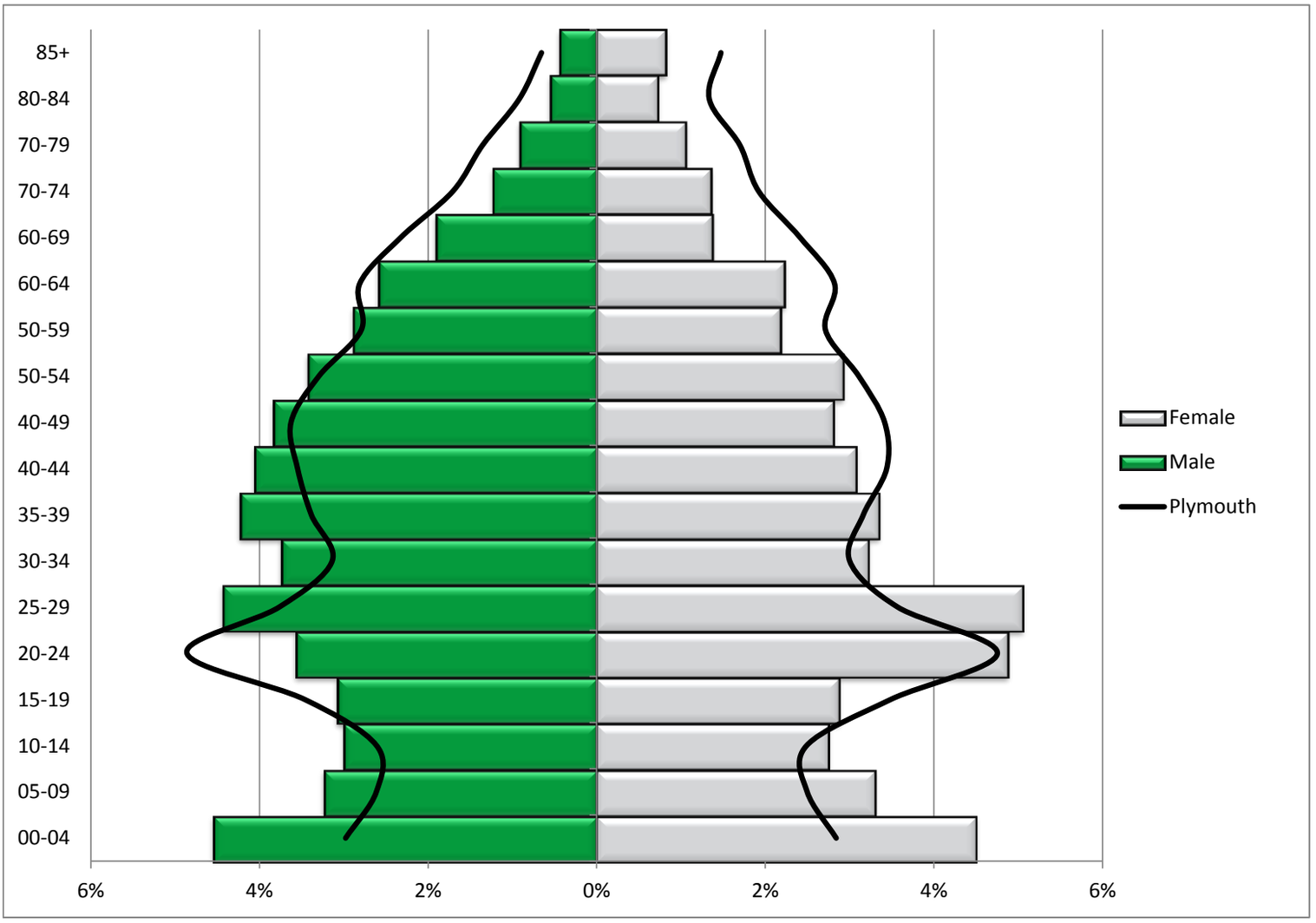
3. Area maps


Devonport Neighbourhood
Yonderberry Point
Thanckes Lake
RPOINT
Gravesend Point
Gravesend Hard
Moon Cove
Tamar Canal
Tamar Wharf
Cross Canal
Torpoint Ferry (Floating Bridges) (Vechicular and Foot)
Dockyard
Morice Town
Devonport
Devonport Park
Riverside Business Park
Football Ground
North Corner Quay
Marina
Hamoaze
Community Centre
The Brickfields (Recreation Ground)
Cricket Ground
Depot
Admiralty House
Mount Wise
Mutton Cove Pier
Landing Place
Ferry (Foot) Terminal
Stoke
Stonehouse
Source:2001 census output area boundaries. Crown copyright 2003.
Crown copyright material is reproduced with the permission of the controller of HMSO.
Digital mapping solutions from Dotted Eyes. Crown copyright 2012.
All rights reserved. Licence number 1000019918.


SALTASH
TORPOINT
PLYMOUTH
Source:2001 census output area boundaries. Crown copyright 2003.
Crown copyright material is reproduced with the permission of the controller of HMSO.
Digital mapping solutions from Dotted Eyes. Crown copyright 2012.
All rights reserved. Licence number 1000019918.

4. Demography

Devonport population pyramid



Age group	Population (number)			Population (percentage)			Plymouth (percentage)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
00-04	288	285	573	4.5	4.5	9.0	**2.8**	**2.7**	**5.5**
05-09	205	209	414	3.2	3.3	6.5	**2.5**	**2.3**	**4.8**
10-19	385	356	741	6.1	5.6	11.7	**5.7**	**5.6**	**11.3**
20-34	744	833	1,577	11.7	13.1	24.9	**14.2**	**13.6**	**27.8**
35-44	525	407	932	8.3	6.4	14.7	**6.5**	**6.2**	**12.7**
45-64	807	642	1,449	12.7	10.1	22.8	**11.8**	**11.3**	**23.1**
65-74	199	173	372	3.1	2.7	5.9	**3.8**	**4.1**	**7.9**
75-84	93	113	206	1.5	1.8	3.2	**2.1**	**2.8**	**5.0**
85+	28	52	80	0.4	0.8	1.3	**0.6**	**1.4**	**2.0**
All ages	3,274	3,070	6,344	51.6	48.4	100.0	**50.0**	**50.0**	**100.0**

Source: GP population register, October 2013

5. Deprivation

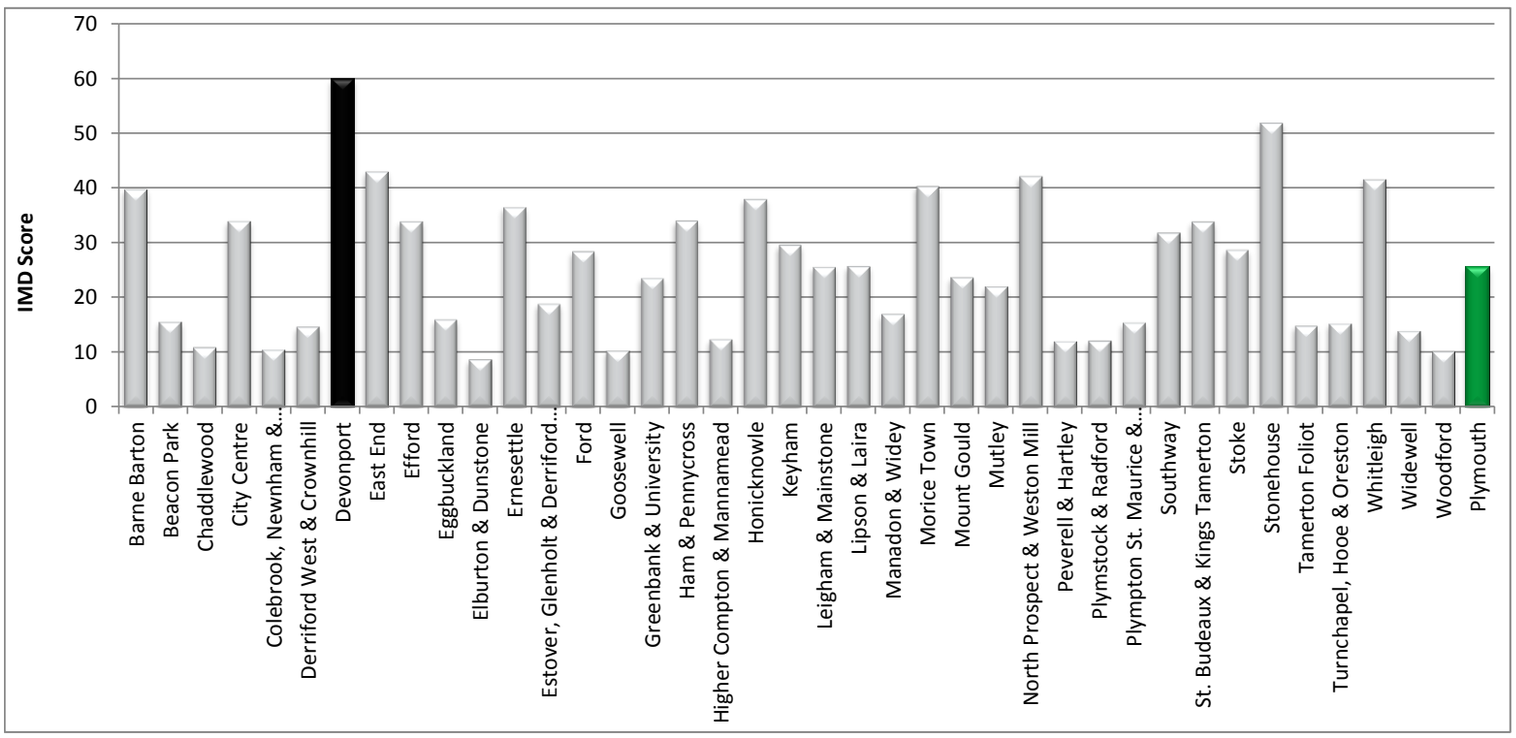
Index of multiple deprivation 2010 Overall domain scores	Area		Plymouth average
	Value	Rank	
Overall IMD score	60.0	1	**25.6**
Barriers to housing and services score	21.3	25	**22.5**
Crime and disorder score	0.5	14	**0.2**
Education, skills and training score	61.7	1	**25.4**
Employment score	0.3	1	**0.1**
Health deprivation and disability score	1.6	1	**0.4**
Income score	0.4	1	**0.2**
Living environment score	47.8	12	**31.5**

Deprivation measures attempt to identify communities where the need for healthcare is greater, material resources are less and as such the capacity to cope with the consequences of ill-health are less. Areas are therefore deprived if there is inadequate education, inadequate housing, unemployment, insufficient income, poor health, and low opportunities for enjoyment. A deprived area is conventionally understood to be a place in which the residents tend to be relatively poor and are relatively likely to suffer from misfortunes such as ill-health.

The Index of Multiple Deprivation 2010 (IMD2010) is the current official measure of deprivation. The IMD2010 combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England. This allows each area to be ranked relative to one another according to their level of deprivation.

The IMD2010 is not routinely available at neighbourhood level, analysis has therefore been carried out by Plymouth City Council, Public Health Team to produce IMD2010 scores for each of the city's 39 neighbourhoods. The higher the score, the more deprived the area is on that measure. The neighbourhoods are ranked from 1 (most deprived) to 39 (least deprived).

Overall IMD2010 scores

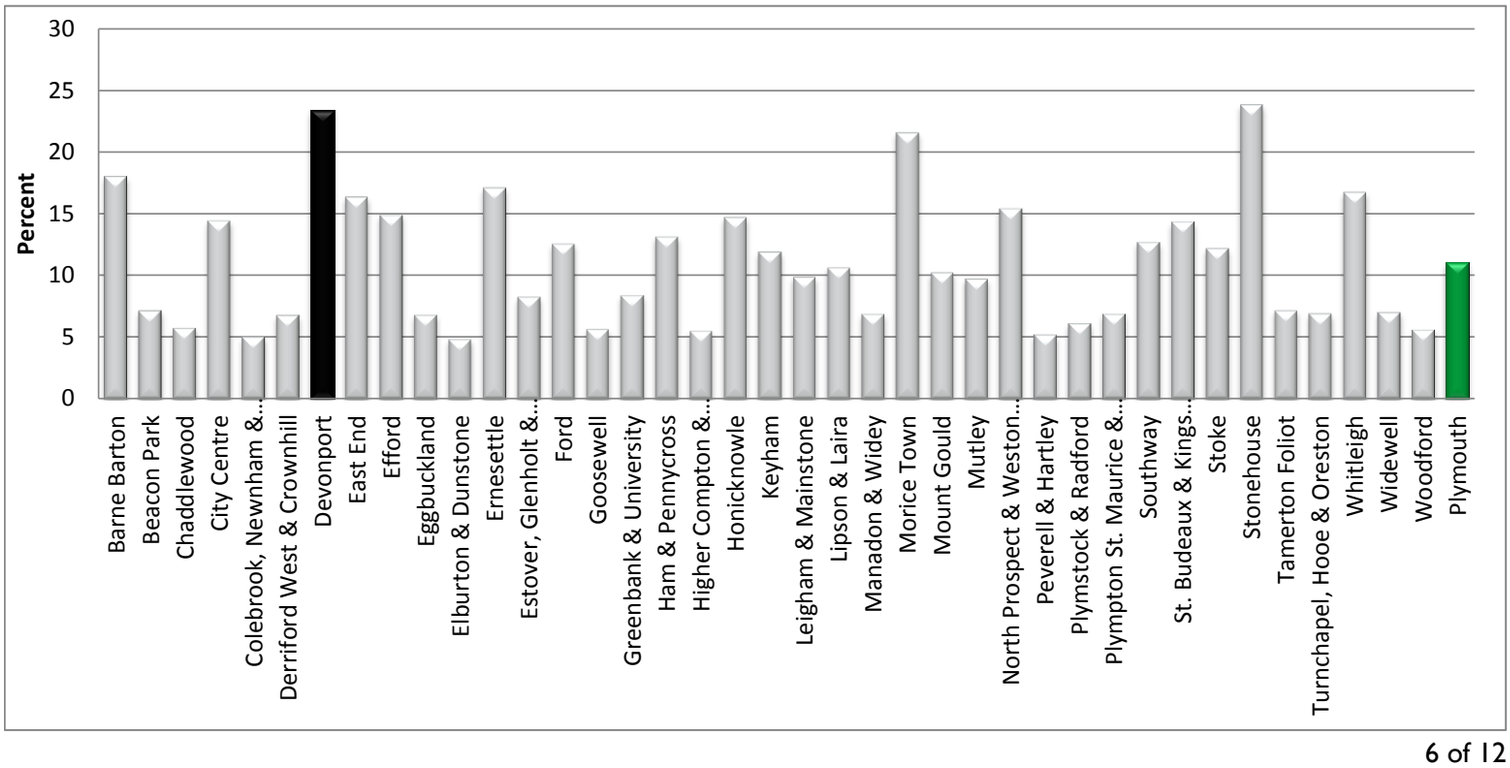


6. Benefits uptake

	2013 (Area)	2013 (Plymouth)	2012 (Area)	2011 (Area)
1. Claimants (%) Feb 2013	23.4	**11.0**	23.6	23.6
2. Jobseekers (%) Feb 2013	10.9	**3.7**	10.5	8.5
3. Employment and support allowance / incapacity benefit (%) Feb 2013	20.2	**8.2**	18.3	17.6
4. Lone parent (%) Feb 2013	4.2	**1.3**	4.4	4.3
5. Carer benefit (%) Feb 2013	3.1	**1.6**	2.9	2.3
6. Income related (%) Feb 2013	0.7	**0.4**	0.9	0.7
7. Disabled (%) Feb 2013	2.7	**1.8**	2.1	2.0
8. Bereaved (%) Feb 2013	0.3	**0.2**	0.3	0.0
9. Male - employment benefits (%) Feb 2013	37.5	**17.0**	38.2	38.3
10. Female- employment benefits (%) Feb 2013	32.2	**16.6**	32.2	32.3
11. 16-24 employment benefits (%) Feb 2013	29.5	**12.3**	33.4	32.3
12. 25-49 employment benefits (%) Feb 2013	34.3	**17.2**	34.3	35.5
13. 50 and over employment benefits (%) Feb 2013	40.8	**20.0**	38.9	37.9

1. Percentage of claimants based on the ONS mid year estimates 2. Percentage of Jobseekers claimants based on the working age population 3. Percentage of employment and support allowance / incapacity benefit claimants based on the working age population 4. Percentage of lone parent claimants based on the working age population 5. Percentage of carer benefit claimants based on the working age population 6. Percentage of income related benefits claimants based on the working age population 7. Percentage of disabled claimants based on the working age population 8. Percentage of bereaved claimants based on the working age population 9. Percentage of male employment benefits claimants based on the working age population 10. Percentage of female employment benefits claimants based on the working age population 11. Percentage of employment benefits claimants aged 16-24 based on the working age population 12. Percentage of employment benefits claimants aged 25-49 based on the working age population 13. Percentage of employment benefits claimants aged 50 and over based on the working age population.

Claimants (%) in Feb 2013

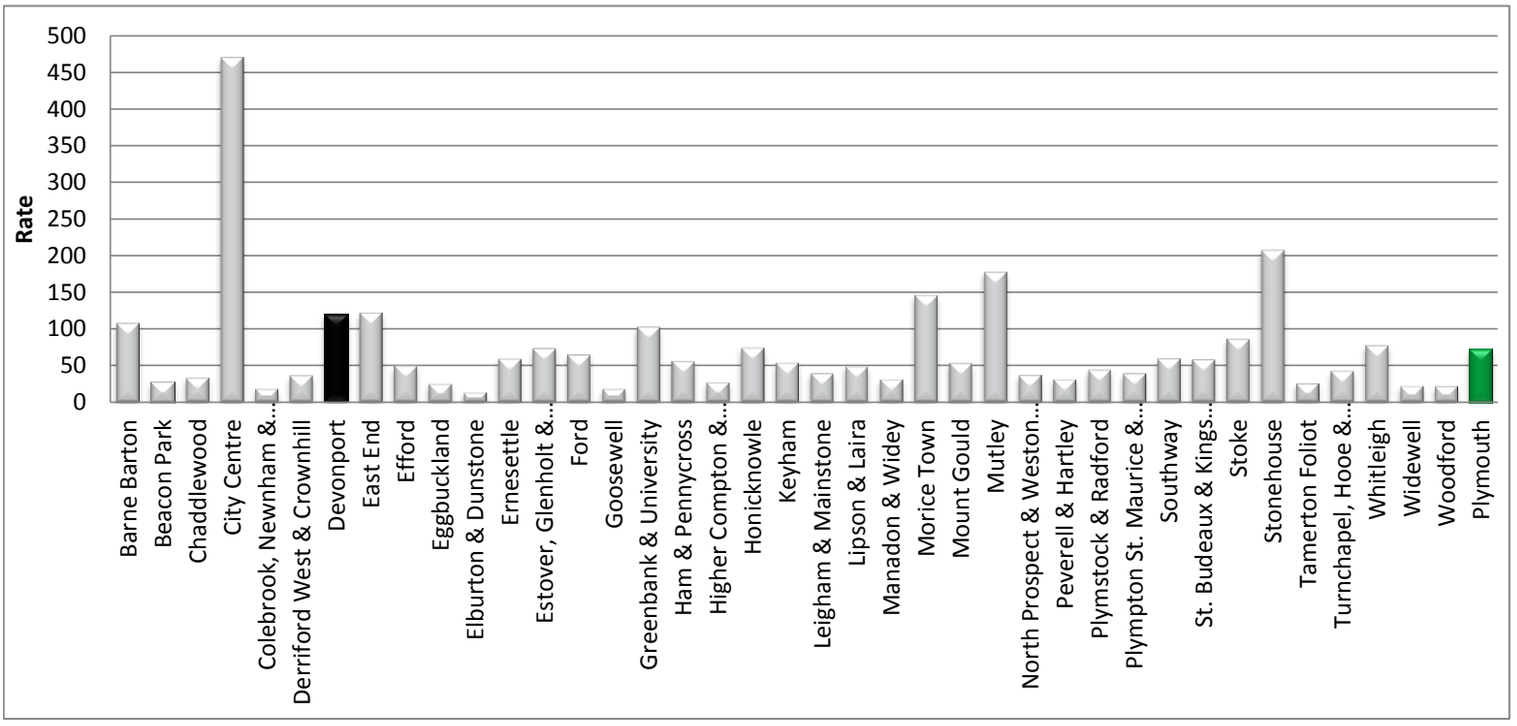


7. Crime

	2012-13 (Area)	2012-13 (Plymouth)	2011-12 (Area)	2010-11 (Area)
1. Anti-social behaviour (rate per 1,000 pop) 2011-12	79.1	**39.5**	97.7	115.4
2. Criminal damage (rate per 1,000 pop) 2012-13	20.6	**12.4**	20.3	18.6
3. Domestic abuse incidents (rate per 1,000 pop) 2012-13	53.3	**24.0**	47.4	48.2
4. Serious acquisitive crime (rate per 1,000 pop) 2012-13	11.2	**8.7**	15.6	11.3
5. Violence with injury (rate per 1,000 pop) 2012-13	19.8	**10.0**	20.3	17.7
6. All crime (rate per 1,000 pop) 2012-13	119.6	**72.4**	181.7	153.4

Please note these statistics are a approximation as Devon and Cornwall Police divide the city in a different way to Plymouth City Council.
1. Incidents of anti-social behaviour (ASB) per 1,000 population recorded by Devon and Cornwall Police. 2. Rate of criminal damage crimes per 1,000 population recorded by Devon and Cornwall Police. 3. Rate of domestic abuse incidents per 1,000 population recorded by Devon and Cornwall Police. Domestic abuse defined by HM Government as 'Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality'. 4. Rate of serious acquisitive crimes per 1,000 population recorded by Devon and Cornwall Police. Serious acquisitive includes; domestic burglary (including religiously and racially aggravated), theft from vehicle (including religiously and racially aggravated) and robbery (including religiously and racially aggravated). 5. Rate of violence with injury crimes per 1,000 population recorded by Devon and Cornwall Police. Violence with injury includes primarily; grievous bodily harm, assault/ occasioning actual bodily harm and malicious wounding. 6. Rate of all crime per 1,000 population recorded by Devon and Cornwall Police.

All crime (per 1,000 resident population) in 2012-13



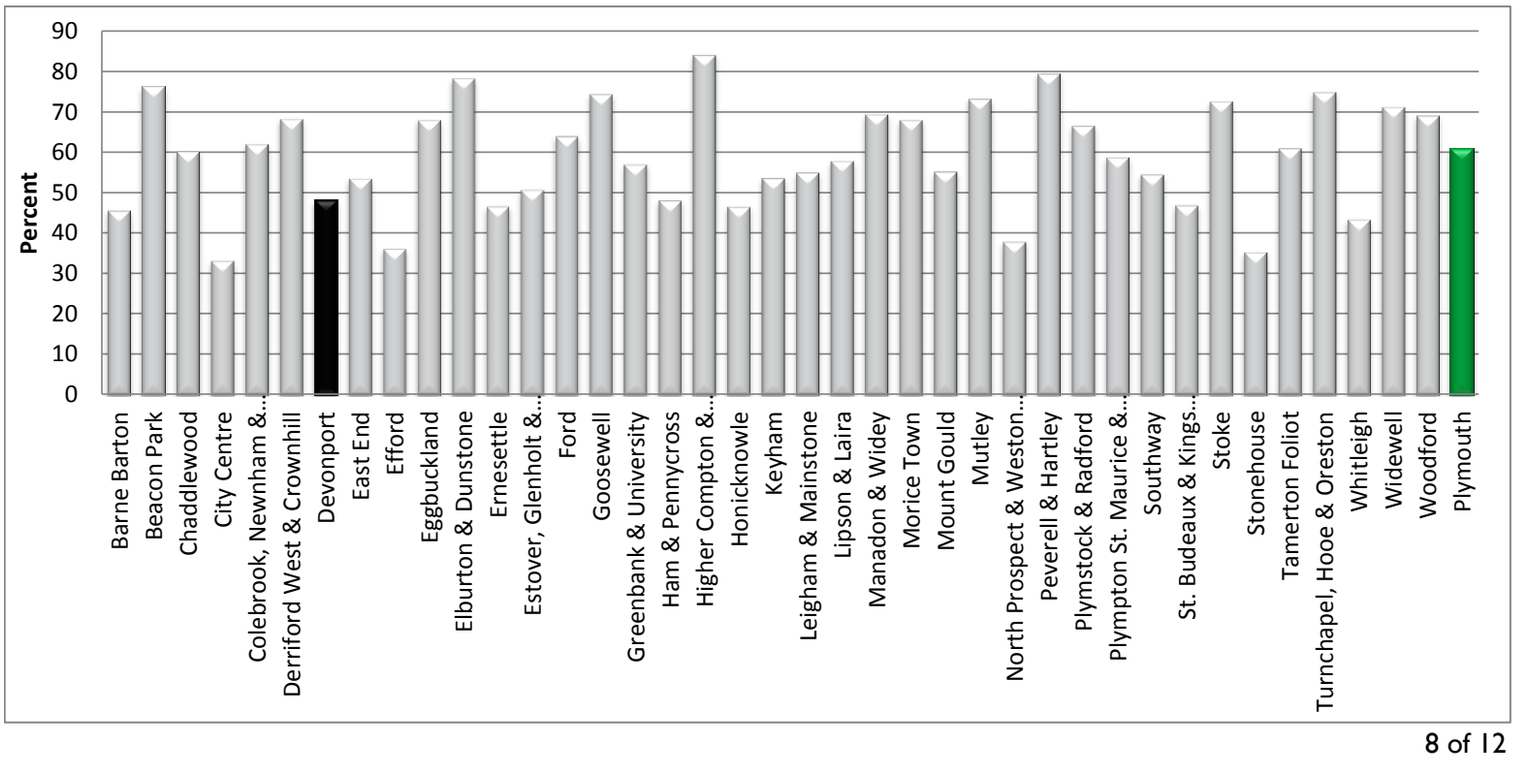
8. Education and children

	2012-13 (Area)	2012-13 (Plymouth)	2011-12 (Area)	2010-11 (Area)
1. Child protection (rate per 10,000 0-17 pop) 2012-13	44.5	**62.9**	400.0	310.3
2. Children in care (rate per 10,000 0-17 pop) 2012-13	203.6	**86.1**	238.7	278.0
3. Children in need (rate per 10,000 0-17 pop) 2012-13	1,545.8	**766.3**	1,658.1	1,868.1
4. Key stage 2 pupils who achieved required Level 4 in Reading , Writing and Maths (%) 2012-13	71.4	**73.2**	61.5	41.5
5. Key stage 2 pupils with free school meal eligibility who achieved required Level 4 in Reading , Writing and Maths (%) 2012-13	66.7	**56.1**	N/A	N/A
6. Permanent exclusions (%) 2012-13	0.00	**0.02**	0.1	-
7. Pupils achieving five or more A*-C grades at GCSE (including English and Maths) (%) 2012-13	48.2	**61.1**	46.6	22.4

**Indicates the data is suppressed; this only applies to certain areas and indicators.

1. Number of children with a children protection plan per 10,000 0-17 population. 2. Rate of children looked after per 10,000 0-17 population. 3. The number of children in need as a rate per 10,000 0-17 population. 4. The percentage of key stage 2 pupils who achieved required level 4 in Reading , Writing and Maths. 5. The percentage of key stage 2 pupils with free school meal eligibility who achieved required level 4 in Reading , Writing and Maths. 6. The percentage of permanent exclusions. 7. The percentage of pupils achieving five or more A*-C grades at GCSE (including English and Maths).

Five or more A*-C grades at GCSE including English and Maths (%) 2012-13



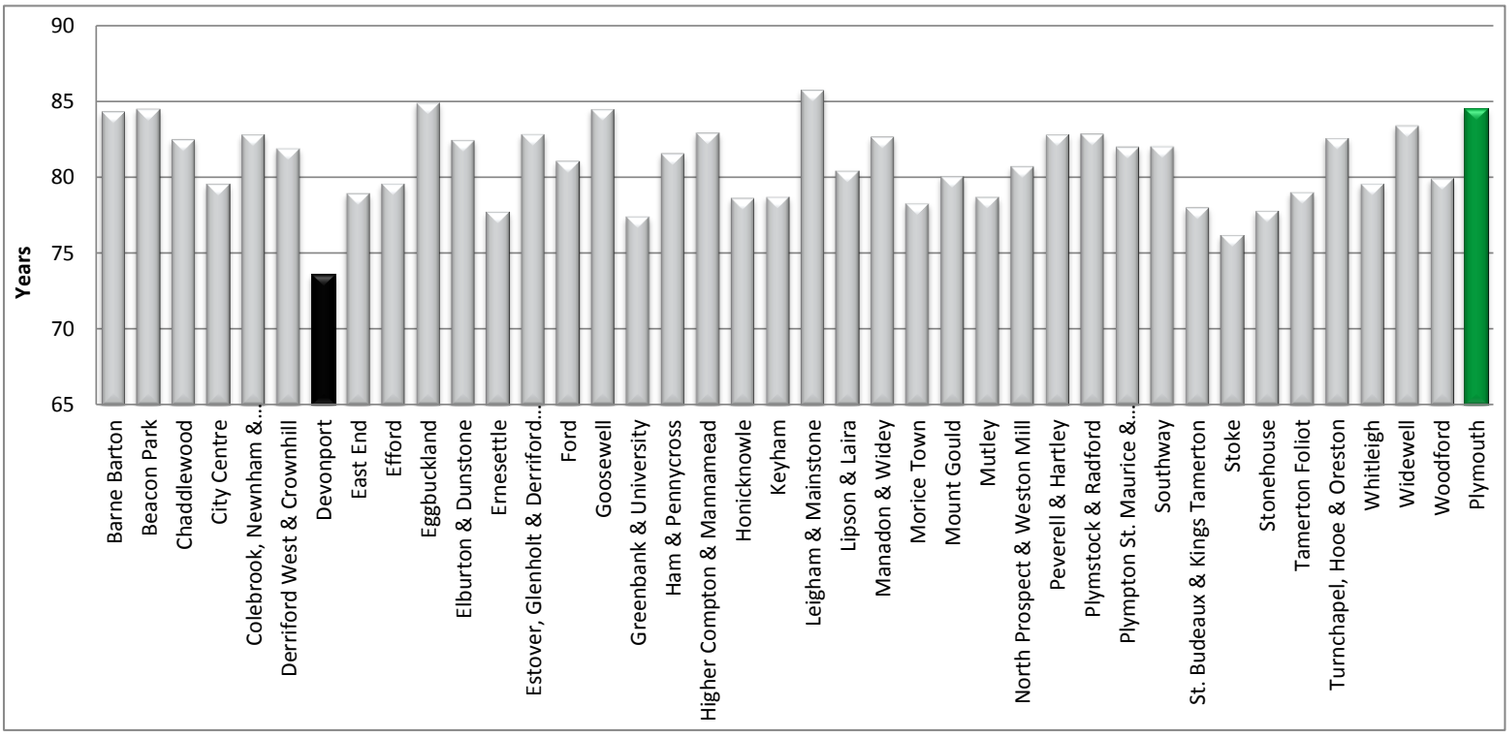
9. Health

	Latest period* (Area)	Latest period* (Plymouth)	Previous period* (Area)	2nd Previous period* (Area)	3rd Previous period* (Area)
1. Life expectancy (years) 2010-12	73.6	**80.5**	72.2	72.7	72.7
2. Smoking in pregnancy (%) 2012	31.0	**16.7**	35.6	28.4	25.0
3. Breastfeeding at 6-8 weeks (%) 2012	23.0	**33.0**	22.1	23.4	28.4
4. Vulnerable families (%) 2012	26.61	**13.0**	24.1	33.4	47.7
5. Excess weight (reception) (%) 2012/13	27.1	**24.9**	30.3	32.5	40.3
6. Excess weight (year 6) (%) 2012/13	37.5	**32.1**	35.6	40.6	42.6
7. Adult smoking (%) 2012/13	36.8	**17.4**	34.8	37.7	N/A
8. Excess weight in adults (%) 2012/13	67.4	**67.3**	61.2	59.4	-
9. Outpatient DNAs (%) 2012/13	10.92	**6.2**	11.2	12.5	N/A
10. Emergency hospital admissions (rate per 10,000 pop) 2012/13	1,232.5	**875.2**	1,179.3	1,370.6	1,525.7
11. Cancer mortality <75s (rate per 10,000 pop) 2012	11.7	**7.2**	16.8	27.7	26.6
12. CVD mortality <75s (rate per 10,000 pop) 2012	21.9	**14.6**	19.2	13.4	19.9
13. All age all cause mortality (rate per 10,000 pop) 2012	83.3	**57.3**	104.2	106.0	101.6

*As the health indicators are not all based on the same time periods, the terms 'latest period', 'previous period', '2nd previous period' and '3rd previous period' have been used. Using this convention and by referring to the specific indicator names, it is possible to determine the time period that each data item refers to. **Indicates the data is suppressed; this only applies to certain areas and indicators.

1. Life expectancy at birth in years. 2. Percentage of women who smoked during pregnancy. 3. Percentage of women breastfeeding at the time of their child's 6-8 week check. 4. Percentage of families classified as vulnerable based on the bi-annual survey of health visitor caseloads. 5. Percentage of children in reception classified as overweight or obese. 6. Percentage of children in year 6 classified as overweight or obese. 7. Percentage of adults who are current smokers. 8. Percentage of adults classified as overweight or obese. 9. Percentage of missed outpatient appointments. 10. Rate of emergency hospital admissions per 10,000 population. 11. Rate of cancer mortality per 10,000 population aged less than 75. 12. Rate of circulatory disease mortality per 10,000 population aged less than 75. 13. All age all cause mortality rate per 10,000 population.

Life expectancy (years) 2010-12



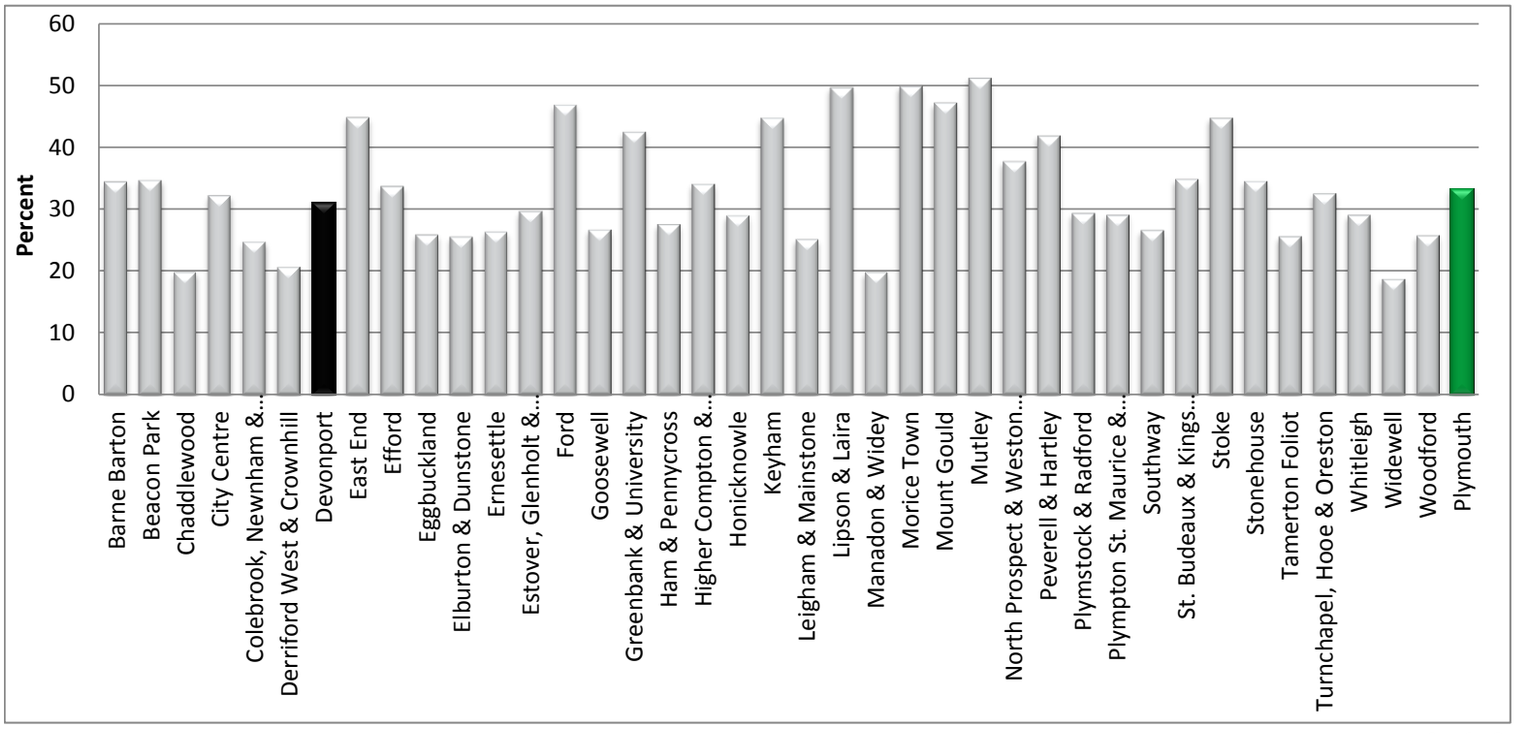
10. Housing

Plymouth's private sector housing stock	2010 (Area)	2010 (Plymouth)
1. Non-decent homes (%) 2010	31.0	**33.3**
2. Thermal comfort (%) 2010	15.6	**14.8**
3. Category 1 hazards (%) 2010	18.2	**20.9**
4. Disrepair (%) 2010	8.2	**11.1**
5. Non-modern amenities (%) 2010	5.0	**4.1**
6. Category 1 excess cold (%) 2010	7.2	**8.9**

1. To be a decent home, the home must be free of category 1 hazards (as measured by the housing health and safety rating system), be in a reasonable state of repair, have reasonably modern facilities and services, and provide a reasonable degree of thermal comfort. 2. Percentage of homes that fail to provide a reasonable degree of thermal comfort (a reasonable degree of thermal comfort is having effective insulation and efficient heating). 3. Percentage of homes that have at least one category 1 hazard as measured by the housing health and safety rating system. 4. Percentage of homes that are not in a reasonable state of repair (need one or more key building components to be replaced or two or more other building components to be replaced). 5. Percentage of homes that don't have reasonably modern facilities and services. 6. Percentage of homes that fall into the excess cold category as measured by the housing health and safety rating system.

For more information about the indicators above see the following web page. http://www.communities.gov.uk/publications/housing/decenthome

Non-decent homes (%) 2010

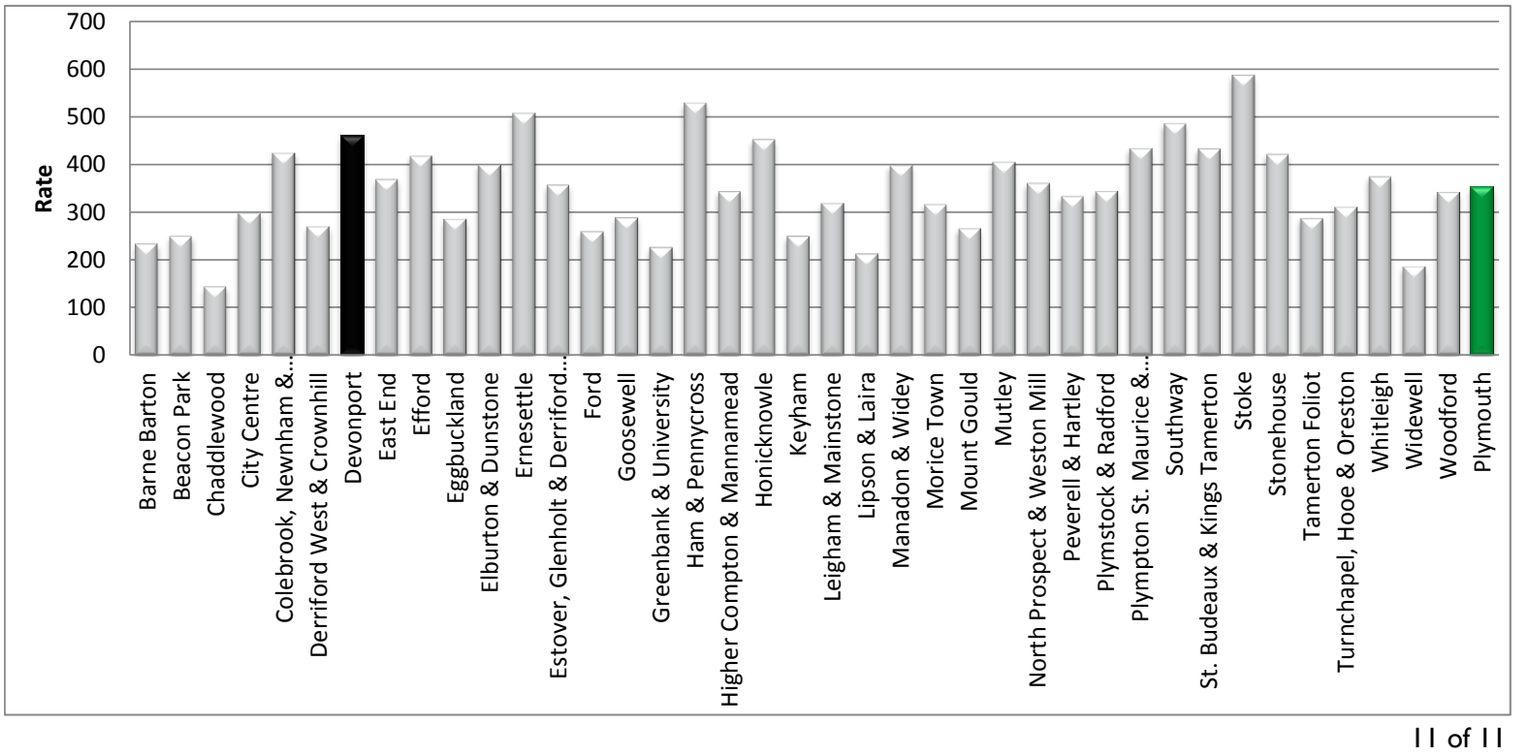


11. Social care

	2012-13 (Area)	2012-13 (Plymouth)	2011-12 (Area)	2010-11 (Area)
1. All clients (rate per 10,000 18+ pop) 2012-13	460.5	**354.5**	396.3	378.7
2. Community based service clients (rate per 10,000 18+ pop) 2012-13	368.8	**261.8**	363.0	340.4
3. Dementia clients (rate per 10,000 18+ pop) 2012-13	58.9	**43.0**	39.6	38.3
4. Learning disabilities 18-64 clients (rate per 10,000 18-64 pop) 2012-13	53.2	**54.3**	48.4	-

1. Number of unique clients in receipt of packages of care during the financial year (includes community based services, residential care and nursing care) as a rate per 10,000 18+ population. 2. Number of unique clients in receipt of community based services (CBS) during the financial year as a rate per 10,000 18+ population. 3. Number of unique clients with dementia as a rate per 10,000 18+ population. 4. Number of unique clients of working age (18-64) with learning disabilities (LD) known to the Council as a rate per 10,000 18-64 population.

All clients (per 10,000 18+ resident population) 2012-13



Public Health England

NATIONAL GENERAL PRACTICE PROFILES

PROFILE FOR

Hyde Park Surgery

Hyde Park Surgery/Lodge, 2 Hyde Park Road, Mutley, Plymouth, Devon

These profiles are designed to support clinical commissioning groups (CCGs), GPs and local authorities to ensure that they are providing and commissioning effective and appropriate healthcare services for their local population. The tool presents a range of practice-level indicators drawn from the latest available data, including:

- local demography;
- Quality and Outcomes Framework (QOF) domains;
- patient satisfaction survey;
- cancer services

In addition to displaying individual practice profiles, the web tool allows you to view summary profiles for CCGs. Each practice can be compared with its CCG and with England, and also with the practices in the same deprivation deciles.

The profiles do not provide an exhaustive list of primary care indicators, but they do allow a consistent approach to comparing and benchmarking across England.

Note: QOF indicators are calculated as percent of patients receiving an intervention.

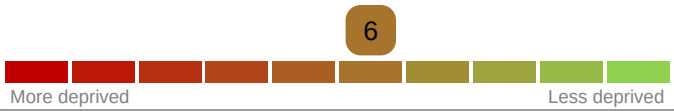
The profiles have been designed as a web tool and the full functionality and various chart types such as scatter plots and trend charts are only available via the web version. For more information consult the User guide and FAQs via the Supporting documents link, and for full metadata view the 'Definitions' on the website.

The development of this tool has been led by the Public Health England Fingertips team. For further information contact: ProfileFeedback@phe.gov.uk

Registered Persons	
Hyde Park Surgery	2,566
NHS Northern, Eastern And Western Devon CCG	7,366 (average)
England	7,324 (average)

Deprivation

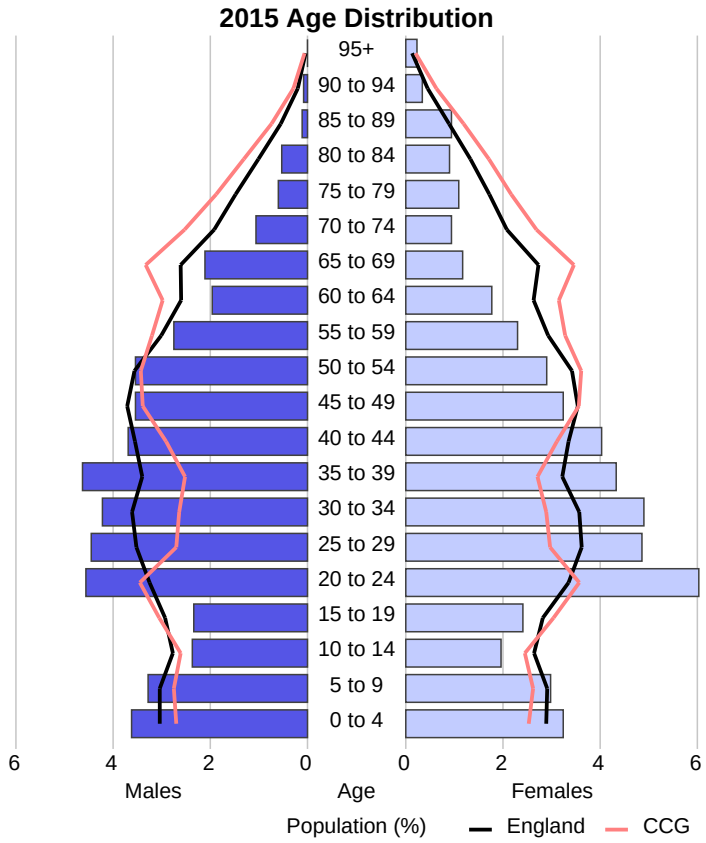
Fifth less deprived decile



QOF achievement	548.5 (out of 559)
Male life expectancy	78.4 years
Female life expectancy	83.6 years
% of patients that would recommend their practice	85.2%

Ethnicity Estimate

1.7% mixed, 2.7% asian, 1.6% other non-white ethnic groups



http://fingertips.phe.org.uk/profile/general-practice

How to read the indicator spine charts

The light grey bar shows the range of values found in England. The dark grey sections mark out the range within which the middle half of the observed values lie (25th to 75th percentile).

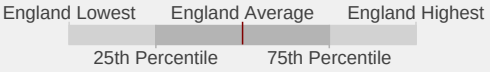
The red line shows where the England average is. The position of the circle shows the practice value, a triangle the CCG value, in relation to this scale.

The corresponding numbers can be found in the cells next to the chart.

If significance has been calculated for the indicator, then it is determined by whether the practice value is significantly higher or lower than the England average usually using 99.8% confidence intervals.

- No significant difference from England average
- Significantly different from England average
- Significance not calculated

- Practice
- Clinical Commissioning Group



Practice Summary

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
% aged 0 to 4 years	2015	6.9%	5.2%	5.9%	0.0%		17.3%
% aged 5 to 14 years	2015	10.6%	10.4%	11.4%	0.0%		30.3%
% aged under 18 years	2015	20.3%	19.3%	20.7%	0.0%		53.5%
% aged 65+ years	2015	10.1%	22.2%	17.1%	0.0%		92.5%
% aged 75+ years	2015	4.8%	10.2%	7.8%	0.0%		79.6%
% aged 85+ years	2015	1.7%	3.1%	2.3%	0.0%		48.2%
Deprivation score (IMD 2015)	2015	21.5	19.9	21.8	3.2		66.5
Deprivation score (IMD 2010)	2012	21.4	19.8	21.5	2.9		68.4
IDACI (Income Depr. - Children)	2015	15.8%	16.1%	19.9%	1.4%		59.3%
IDAOPI (Income Depr. - Older People)	2015	18.4%	13.6%	16.2%	3.9%		65.3%
% who would recommend practice	2014/15	85.2%	85.6%	77.5%	15.2%		100%
% satisfied with phone access	2014/15	91.9%	84.4%	73.3%	11.9%		100%
% satisfied with opening hours	2014/15	80.3%	77.5%	74.9%	38.7%		100%
% who saw/spoke to nurse or GP same or next day	2014/15	34.8%	49.3%	48.3%	6.5%		98.3%
% reporting good overall experience of making appointment	2014/15	90.2%	83.3%	73.3%	16.8%		100%
% who know how to contact an out-of-hours GP service	2014/15	60.0%	66.1%	56.4%	11.9%		87.3%
% with a long-standing health condition	2014/15	48.9%	56.5%	54.0%	11.9%		94.7%
% with caring responsibility	2014/15	17.7%	19.2%	18.2%	0.5%		36.9%
Working status - Paid work or full-time education	2014/15	70.1%	59.1%	61.5%	8.5%		100%
Working status - Unemployed	2014/15	5.9%	4.0%	5.4%	0.4%		53.6%
Total QOF points	2014/15	98.1%	95.1%	94.8%	28.2%		100%
Life expectancy - MSOA based (Male)	2008 - 12	78.4	79.6	78.9	70.0		90.1
Life expectancy - MSOA based (Female)	2008 - 12	83.6	83.4	82.8	75.9		91.9
Nursing home patients	2014/15	0.2%	0.7%	0.5%	0.0%		14.9%

Cancer

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Cancer: QOF prevalence (all ages)	2014/15	2.0%	2.7%	2.3%	0.0%		6.2%
Exception rate for cancer indicator	2014/15	0.0%	17.1%	15.4%	0.0%		100%
New cancer cases (Crude incidence rate: new cases per 100,000 population)	2012/13	490	631	508	0		1593
% reporting cancer in the last 5 years	2014/15	3.2%	3.8%	3.3%	0.3%		11.9%
CAN003: review within 6 mths of diagnosis	2014/15	100%	79.4%	80.1%	0.0%		100%
Exception rate for the cervical screening indicator	2014/15	5.6%	5.2%	6.2%	0.0%		62.2%
CS002: Women, aged 25-64, with a record of cervical screening (last 5 yrs) (Female)	2014/15	73.6%	78.0%	76.7%	0.0%		100%
Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %) (Female)	2014/15	72.3%	76.9%	73.5%	0.0%		100%
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (Female)	2014/15	67.1%	78.1%	72.2%	0.0%		94.1%
Females, 50-70, screened for breast cancer within 6 months of invitation (Uptake, %) (Female)	2014/15	45.5%	77.1%	72.8%	0.0%		100%
Persons, 60-69, screened for bowel cancer within 6 months of invitation (Uptake, %)	2014/15	47.1%	62.0%	57.6%	0.0%		100%
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	2014/15	53.8%	62.7%	57.9%	10.1%		100%
Two-week wait referrals (Indirectly age-sex standardised referral ratio)	2014/15	91	1	100	0		614
Number of new cancer cases treated (Detection rate: % of which resulted from a TWW referral)	2014/15	88.9%	53.3%	48.4%	0.0%		100%
Two-week wait referrals for suspected breast cancer (Number per 100,000 population)	2014/15	546	595	482	0		1645
Two-week wait referrals for suspected lower GI cancers (Number per 100,000 population)	2014/15	273	529	421	0		2176
Two-week wait referrals for suspected lung cancer (Number per 100,000 population)	2014/15	116.9	110.0	100.5	0.0		824.7
Two-week wait referrals for suspected skin cancer (Number per 100,000 population)	2014/15	273	824	508	0		3465
In-patient or day-case colonoscopy procedures (Number per 100,000 population)	2014/15	429	806	695	0		2105
In-patient or day-case sigmoidoscopy procedures (Number per 100,000 population)	2014/15	117	422	431	0		1922
In-patient or day-case upper GI endoscopy procedures (Number per 100,000 population)	2014/15	585	1053	1142	28		3576
Number of emergency admissions with cancer (Number per 100,000 population)	2014/15	117	549	539	6		2970
Number of emergency presentations (Number per 100,000 population)	2014/15	39	104	90	0		721
Number of other presentations (Number per 100,000 population)	2014/15	234	491	360	0		1186

CVD - Coronary heart disease

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
CHD: QOF prevalence (all ages)	2014/15	2.1%	3.9%	3.2%	0.0%		20.9%
Heart failure w LVD: QOF prevalence	2014/15	0.4%	0.2%	0.2%	0.0%		2.2%
Exception rate for CHD indicators (2014/15 indicators)	2014/15	12.0%	9.4%	8.4%	0.0%		66.7%
CHD002: Last BP reading in last 12mths is <=150/90 (den.incl.exc.)	2014/15	90.6%	87.3%	88.4%	0.0%		100%
CHD003: Last total cholesterol is <=5mmol/l (den. incl. exc.) - retired	2013/14	74.5%	70.3%	73.2%	0.0%		100%
CHD005: Record that aspirin, APT or ACT is taken (den. incl. exc.)	2014/15	94.3%	92.0%	91.7%	0.0%		100%
CHD007: CHD patients immunised against flu (den.incl.exc.)	2014/15	73.6%	80.1%	81.2%	0.0%		100%
CHD006: History of MI: treated with ACE-I (den. incl. exc.)	2014/15	75.0%	64.0%	69.1%	0.0%		100%

CVD - Stroke and TIA

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Stroke: QOF prevalence (all ages)	2014/15	1.9%	2.2%	1.7%	0.0%		20.3%
Exception rate for stroke indicators (2014/15 indicators)	2014/15	13.1%	10.4%	9.7%	0.0%		66.7%
Exception rate for PAD indicators (2014/15 indicators)	2014/15	2.4%	6.6%	5.8%	0.0%		73.9%
STIA003: Last BP reading is =150/90 (den. incl. exc.)	2014/15	83.7%	83.6%	84.3%	0.0%		100%
STIA004: Total cholesterol recorded in last 15mths (den. incl. exc.) - retired	2013/14	81.3%	82.6%	84.5%	0.0%		100%
STIA005: Last measured total cholesterol <=5mmol/l (den. incl. exc.) - retired	2013/14	62.1%	64.4%	68.4%	0.0%		100%
STIA007: Record that an anti-platelet agent or an anti-coagulant is taken (den. incl. exc.)	2014/15	96.6%	92.9%	91.7%	0.0%		100%
STIA008: New patients referred for further investigation (den.incl.exc.)	2014/15	66.7%	75.0%	76.6%	0.0%		100%
STIA009: Influenza immunisation given 1 Aug-31 Mar (den.incl.exc.)	2014/15	69.4%	77.3%	77.5%	0.0%		100%
PAD002: last blood pressure reading (last 12 mnths) <=150/90 mmHg (den.incl.exc.)	2014/15	95.7%	84.0%	85.6%	0.0%		100%
PAD003: last total cholesterol measurement (last 12 mnths) <= 5.0 mmol/l (den.incl.exc.) - retired	2013/14	65.0%	66.1%	69.4%	0.0%		100%
PAD004: record of aspirin being taken (last 12 mnth) (den.incl.exc.)	2014/15	100%	88.1%	86.4%	0.0%		100%

CVD - Heart failure and atrial fibrillation

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Heart Failure: QOF prevalence (all ages)	2014/15	0.7%	0.8%	0.7%	0.0%		6.0%
Heart failure w LVD: QOF prevalence	2014/15	0.4%	0.2%	0.2%	0.0%		2.2%
Exception rate for heart failure indicators	2014/15	20.0%	12.5%	9.2%	0.0%		78.0%
Atrial fibrillation: QOF prevalence	2014/15	1.0%	2.2%	1.6%	0.0%		14.1%
Estimated prevalence of Atrial Fibrillation	2013/14	1.6%	3.0%	2.4%	0.0%		16.7%
Estimated prevalence of Atrial Fibrillation (Male)	2013/14	1.7%	3.5%		0.1%		17.2%
Estimated prevalence of Atrial Fibrillation (Female)	2013/14	1.5%	2.5%		0.0%		16.4%
Estimated percentage of detected Atrial Fibrillation	2013/14	63.4	68.9	65.2	0.0		131.9
Exception rate for atrial fibrillation indicators (2014/15 indicators)	2014/15	6.3%	11.4%	11.0%	0.0%		100%
HF002: Diagnosis conf. by ECG/specialist assessm. (den. incl. exc.)	2014/15	92.9%	88.1%	90.9%	0.0%		100%
HF003: Heart failure w LVD: treated with ACE-I or ARB (den. incl. exc.)	2014/15	88.9%	83.1%	86.0%	0.0%		100%
HF004: Heart failure w LVD: treatment w ACE inh. or ARB, and beta-blocker (den.incl.exc.)	2014/15	42.9%	70.3%	76.3%	0.0%		100%
AF002: stroke risk assessed with CHADS2 (last 12 mnths) (den.incl.exc.) - retired	2013/14	73.3%	92.7%	95.0%	0.0%		100%
AF004: treated w anti-coag. therapy (CHADS2 >1) (den.incl.exc.)	2014/15	91.7%	77.0%	74.3%	0.0%		100%
AF005: treated w anti-coag./platelet therapy (if CHADS2 =1) (den.incl.exc.)	2014/15	75.0%	92.4%	92.2%	0.0%		100%

CVD - Risk factors for CVD

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Hypertension: QOF prevalence (all ages)	2014/15	8.0%	15.2%	13.8%	0.1%		47.6%
Exception rate for hypertension indicator (2014/15)	2014/15	8.8%	5.0%	3.8%	0.0%		46.9%
Exception rate for the BP indicator	2014/15	1.3%	0.6%	0.4%	0.0%		49.9%
Obesity: QOF prevalence (16+)	2014/15	9.9%	10.1%	9.0%	0.0%		29.4%
Estimated smoking prevalence (QOF)	2014/15	23.7	17.3	18.4	0.0		83.3
Exception rate for smoking indicators (2014/15 indicators)	2014/15	2.1%	1.3%	1.0%	0.0%		65.0%
GP patient survey: smoking prevalence	2014/15	20.3%	15.6%	16.4%	1.3%		85.8%
GP patient survey: ex-smoking prevalence	2014/15	23.7%	30.6%	27.4%	0.5%		51.3%
SMOK001: record of smoking status in last 24 months (15+ y), den. incl. exc. - retired	2013/14	85.9%	83.2%	85.6%	2.1%		100%
SMOK002: status recorded in last 12 mths (certain conditions), den.incl.exc.	2014/15	90.7%	93.5%	93.2%	0.0%		100%
SMOK004: record of offer of support and treatment (15+, last 24 mnths), den. incl. exc.	2014/15	92.6%	84.9%	85.8%	0.0%		100%
SMOK005: cessation support and treatment offered (certain conditions), den. incl. exc.	2014/15	99.1%	93.3%	94.1%	12.6%		100%
HYP006: Blood pressure <= 150/90 mmHg in people with hypertension	2014/15	77.0%	80.2%	80.4%	0.0%		100%
HYP003: Last (9mnths) blood pressure <= 140/90 mmHg (age <80) (den.incl.exc.) - retired	2013/14	46.5%	64.1%	70.4%	0.0%		98.9%
HYP004: Phys. act. assessment (last 12 mnths), patients with hypertension aged 16-74 (den.incl.exc.) - retired	2013/14	50.9%	62.5%	76.0%	0.0%		100%
HYP005: Patients w. hypertension who had a phys. act. assessment and where found to be inactive who had also a brief intervention (both in last 12mnths, aged 16-74) (den.incl.exc.) - retired	2013/14	85.1%	78.4%	86.3%	0.0%		100%
BP002: Patients, aged 45+, who have a record of blood pressure (last 5yrs)	2014/15	91.4%	91.1%	90.6%	0.0%		100%
CVD-PP001: new hypertension patients, age 30-74, with CV risk assessment >=20% treated w. statins (den.incl.exc.)	2014/15	100%	65.5%	67.7%	0.0%		100%
CVD-PP002: Lifestyle advice for patients with hypertension (den. incl. exc.) - retired	2013/14	61.1%	66.4%	79.0%	0.0%		100%

Child health

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
% aged 0 to 4 years	2015	6.9%	5.2%	5.9%	0.0%		17.3%
% aged 5 to 14 years	2015	10.6%	10.4%	11.4%	0.0%		30.3%
% aged under 18 years	2015	20.3%	19.3%	20.7%	0.0%		53.5%
IDACI (Income Depr. - Children)	2015	15.8%	16.1%	19.9%	1.4%		59.3%
A&E attendances (0-4)	2011/12 - 13/14	259	471	530	22		2705
A&E attendances (5-17)	2011/12 - 13/14	171	301	307	5		1145
A&E attendances (<18)	2011/12 - 13/14	202	347	373	11		1504
Elective hospital admissions for all causes (<18)	2011/12 - 13/14	36.6	47.7	49.0	1.6		249.1
Emergency hospital admissions for all causes (<18)	2011/12 - 13/14	71.2	65.8	69.5	2.5		270.0
Emergency respiratory admissions (<18)	2009/10 - 13/14	-	3.8	3.8	0.4		14.5
Emergency gastroenteritis admissions (0-4)	2009/10 - 13/14	7.8	11.4	11.3	0.8		72.1
Emergency admissions for asthma, diabetes or epilepsy (<18)	2009/10 - 13/14	-	3.0	3.4	0.4		54.7
Admissions due to injury (<18)	2011/12 - 13/14	12.0	10.6	11.1	0.7		52.8
Outpatient first attendances (<18)	2011/12 - 13/14	296	282	246	6		1144
Ratio of first to follow-up outpatient attendances (<18)	2011/12 - 13/14	0.52	0.46	0.51	0.20		2.14
DNA rate for outpatient appointments (<18)	2011/12 - 13/14	8.5%	10.7%	11.5%	0.6%		32.3%

Chronic Kidney Disease

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
CKD: QOF prevalence (18+)	2014/15	3.7%	4.9%	4.1%	0.0%		23.8%
Exception rate for CKD indicators	2014/15	6.1%	9.5%	7.5%	0.0%		60.0%
CKD002: Last BP reading measured in last 12mths is <=140/85 (den. incl. exc.)	2014/15	87.0%	71.1%	74.4%	0.0%		100%
CKD003: Hypertension treated with ACE inhibitor/ARB (den. incl. exc.)	2014/15	88.9%	76.0%	76.4%	0.0%		100%
CKD004: Urine albumin:creatinine ratio test last 12 mths (den. incl. exc.)	2014/15	83.1%	75.8%	75.4%	0.0%		100%

Diabetes

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Diabetes: QOF prevalence (17+)	2014/15	4.5%	6.5%	6.4%	0.3%		20.4%
Exception rate for diabetes indicators (2014/15 indicators)	2014/15	13.5%	12.6%	10.8%	0.0%		49.0%
Hypertension: QOF prevalence (all ages)	2014/15	8.0%	15.2%	13.8%	0.1%		47.6%
Exception rate for hypertension indicator (2014/15)	2014/15	8.8%	5.0%	3.8%	0.0%		46.9%
Exception rate for smoking indicators (2014/15 indicators)	2014/15	2.1%	1.3%	1.0%	0.0%		65.0%
Obesity: QOF prevalence (16+)	2014/15	9.9%	10.1%	9.0%	0.0%		29.4%
DM007: Last HbA1c is <=59mmol/mol in last 12mths (den. incl. exc.)	2014/15	51.6%	60.3%	60.4%	0.0%		100%
DM008: Last HbA1c is <=64mmol/mol in last 12mths (den. incl. exc.)	2014/15	61.3%	68.7%	68.4%	0.0%		100%
DM009: Last HbA1c is <=75mmol/mol in last 12mths (den. incl. exc.)	2014/15	75.3%	80.4%	79.3%	0.0%		100%
DM002: Last BP is <=150/90 (den. incl. exc.)	2014/15	83.9%	85.4%	86.6%	0.0%		100%
DM003: Last BP is <=140/80 (den. incl. exc.)	2014/15	76.3%	67.2%	71.2%	0.0%		100%
DM004: Measured total cholesterol (last 12mths) <=5mmol/l(den.incl.exc.)	2014/15	76.3%	70.2%	70.8%	0.0%		100%
DM005: Record of micro-albuminuria test last 12mths (den. incl. exc.) - retired	2013/14	66.7%	76.7%	80.6%	1.1%		100%
DM006: Proteinuria/micro-album. treated w inhibitors (den. incl. exc.)	2014/15	92.3%	79.2%	81.2%	0.0%		100%
DM011: record of retinal screening (den.incl.exc.) - retired	2013/14	74.4%	77.4%	82.6%	0.0%		100%
DM012: Patients with diabetes who had a foot examination and risk classification (den.incl.exc.)	2014/15	81.7%	81.7%	81.5%	0.0%		100%
DM013: Patients with diabetes who had a dietary review (last 12mths) (den.incl.exc.) - retired	2013/14	46.7%	75.9%	82.2%	0.0%		100%
DM014: Newly diagnosed patients w. diabetes referred to education programme within 9 mths (den.incl.exc.)	2014/15	100%	49.6%	66.3%	0.0%		100%
DM015: Male patients w. diabetes asked about erectile disfunction (last 12 mths) (den.incl.exc.) - retired (Male)	2013/14	48.1%	69.8%	81.6%	0.0%		100%
DM016: Male patients w. diabetes w. erectile disfunction who got advice (den.incl.exc.) - retired (Male)	2013/14	75.0%	77.8%	87.9%	0.0%		100%
DM018: Flu vaccination coverage (den.incl.exc.)	2014/15	82.8%	76.4%	77.6%	37.0%		100%

Mental Health

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Mental Health: QOF prevalence (all ages)	2014/15	1.44%	0.85%	0.88%	0.06%		15.57%
Exception rate for MH indicators (2014/15 indicators)	2014/15	18.2%	11.8%	11.1%	0.0%		76.7%
Dementia: QOF prevalence (all ages)	2014/15	1.1%	0.9%	0.7%	0.0%		59.2%
% reporting Alzheimer's disease or dementia	2014/15	2.0%	0.9%	1.0%	0.3%		25.0%
Exception rate for dementia indicators	2014/15	14.7%	9.8%	8.3%	0.0%		100%
Depression: QOF incidence (18+) - new diagnosis	2014/15	1.8	1.3	1.2	0.0		18.2
Depression: QOF prevalence (18+)	2014/15	9.8%	8.1%	7.3%	0.0%		33.0%
Exception rate for depression indicator (2014/15 indicators)	2014/15	21.1%	25.5%	24.5%	0.0%		100%
% reporting a long-term mental health problem	2014/15	5.9%	4.8%	5.1%	0.4%		60.1%
MH002: comprehensive care plan (den. incl. exc.)	2014/15	63.6%	74.7%	77.2%	0.0%		100%
MH007: record of alcohol consumption for patients on the MH register (last 12 mnths), den. incl. exc.	2014/15	72.7%	77.1%	80.3%	0.0%		100%
MH006: record of BMI for patients on the MH register in preceding 12 months (den.incl.exc.) - retired	2013/14	54.8%	75.3%	78.8%	0.0%		100%
MH003: record of blood pressure check in preceding 12 months for patients on the MH register (den.incl.exc.)	2014/15	84.8%	79.7%	81.5%	0.0%		100%
MH008: Female patients (25-64 yrs) on the MH register who had cervical screening test in preceding 5 years (den. incl. exc.)	2014/15	85.7%	71.5%	71.6%	0.0%		100%
MH009: Patients on lithium therapy with record of serum creatinine and TSH in the preceding 9 months (den.incl.exc.)	2014/15	100%	93.9%	93.4%	0.0%		100%
MH010: Patients on lithium therapy with levels in therapeutic range in preceding 4 months (den.incl.exc.)	2014/15	100%	84.0%	82.6%	0.0%		100%
MH004: Patients on MH register with cholesterol check in preceding 12 months (den.incl.exc.) - retired	2013/14	53.8%	61.4%	68.0%	0.0%		100%
MH005: Patients on the MH register with blood glucose or HbA1c check in preceding 12 months (den.incl.exc.) - retired	2013/14	46.7%	71.0%	74.9%	0.0%		100%
DEP001: Newly diagnosed patients w. depression who had a bio-psychosocial assessment on diagnosis (current FY, aged 18+) (den.incl.exc.) - retired	2013/14	48.0%	68.3%	75.8%	0.0%		100%
DEP003: Newly diagnosed patients with depression who had a review 10-56 days after diagnosis (den.incl.exc.)	2014/15	65.8%	63.4%	63.8%	0.0%		100%
DEM002: Dementia care has been reviewed last 12mths (den.incl.exc.)	2014/15	66.7%	77.9%	77.0%	0.0%		100%
DEM003: Blood tests recorded (den.incl.exc.)	2014/15	57.1%	73.1%	74.7%	0.0%		100%

Musculoskeletal Conditions

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Osteoporosis: QOF prevalence (50+)	2014/15	0.3	0.2	0.2	0.0		9.6
Exception rate for OST indicators	2014/15	0.0%	13.0%	12.5%	0.0%		100%
Rheumatoid Arthritis: QOF prevalence (16+)	2014/15	0.81	0.82	0.73	0.00		4.60
Exception rate for RA indicators (2014/15 indicators)	2014/15	5.9%	8.4%	7.4%	0.0%		82.8%
% reporting a long-term back problem	2014/15	14.0%	9.6%	9.9%	0.0%		38.4%
% reporting arthritis or long-term joint problem	2014/15	7.1%	13.4%	12.8%	0.4%		34.9%
OST002: currently treated with a bone-sparing agent (50-74 yrs)(den.incl.exc.)	2014/15	100%	82.7%	82.8%	0.0%		100%
OST005: Patients (75+ yrs) with a fragility fracture treated with bone-sparing agent (den.incl.exc.)	2014/15	100%	78.4%	79.3%	0.0%		100%
RA002: Patients with rheumatoid arthritis who had a face-to-face review (last 12 mnths) (den.incl.exc.)	2014/15	88.2%	84.7%	84.3%	0.0%		100%
RA003: Patients w. rheumatoid arthritis, aged 30-84, who had an RA adjusted CV risk assessment (last 12 mnths) (den.incl.exc.) - retired	2013/14	92.9%	75.0%	86.8%	0.0%		100%
RA004: Patients w. rheumatoid arthritis, aged 50-90, who had an RA adjusted fracture risk assessment (last 24 mnths) (den.incl.exc.) - retired	2013/14	100%	68.5%	82.1%	0.0%		100%

Respiratory Disease

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
COPD: QOF prevalence (all ages)	2014/15	1.4%	2.0%	1.8%	0.0%		9.0%
Exception rate for COPD indicators	2014/15	7.7%	12.6%	12.3%	0.0%		57.8%
Asthma: QOF prevalence (all ages)	2014/15	7.6%	6.7%	6.0%	0.7%		12.5%
Exception rate for asthma indicators	2014/15	1.6%	9.4%	6.8%	0.0%		63.7%
Estimated smoking prevalence (QOF)	2014/15	23.7	17.3	18.4	0.0		83.3
Exception rate for smoking indicators (2014/15 indicators)	2014/15	2.1%	1.3%	1.0%	0.0%		65.0%
GP patient survey: smoking prevalence	2014/15	20.3%	15.6%	16.4%	1.3%		85.8%
GP patient survey: ex-smoking prevalence	2014/15	23.7%	30.6%	27.4%	0.5%		51.3%
COPD007: Influenza immunisation given 1 Aug - 31 Mar (den. incl. exc.)	2014/15	77.8%	80.8%	81.5%	0.0%		100%
COPD004: Record of FEV1 in last 12mths (den. incl. exc.)	2014/15	88.9%	75.8%	73.2%	0.0%		100%
COPD003: assessed using MRC dyspnoea score last 12mths (den. incl. exc.)	2014/15	86.1%	79.5%	79.9%	0.0%		100%
COPD002: Diagnosis conf. by spirometry (den. incl. exc.)	2014/15	92.9%	79.5%	81.1%	0.0%		100%
AST002: with measures of variability/reversibility (8+), den. incl. exc.	2014/15	80.9%	83.6%	84.3%	0.0%		100%
AST003: review in the last 12 months (incl. an assessment using the 3 RCP questions), den. incl. exc.	2014/15	71.8%	67.8%	69.7%	0.0%		100%
AST004: smoking recorded in last 12 mths (14-19y w asthma), den. incl. exc.	2014/15	90.9%	81.2%	83.9%	0.0%		100%
SMOK002: status recorded in last 12 mths (certain conditions), den.incl.exc.	2014/15	90.7%	93.5%	93.2%	0.0%		100%
SMOK005: cessation support and treatment offered (certain conditions), den. incl. exc.	2014/15	99.1%	93.3%	94.1%	12.6%		100%
SMOK001: record of smoking status in last 24 months (15+ y), den. incl. exc. - retired	2013/14	85.9%	83.2%	85.6%	2.1%		100%
SMOK004: record of offer of support and treatment (15+, last 24 mnths), den. incl. exc.	2014/15	92.6%	84.9%	85.8%	0.0%		100%
COPD005: Patients w. MRC dyspnoea score >=3 w.oxygen saturation value (last 12mths) (den.incl.exc.)	2014/15	95.2%	94.6%	94.5%	0.0%		100%

AMR Local indicators

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Total number of prescribed antibiotic items per 1000 registered patients by quarter	2016 Q1	146.8	161.1	160.2	0.1		2119.7
Total number of prescribed antibiotic items per STAR-PU by quarter	2016 Q1	0.26	0.27	0.30	0.00		4.06
Percentage of broad spectrum prescribed antibiotic items (cephalosporin, quinolone and co-amoxiclav class) by quarter	2016 Q1	14.59%	10.96%	9.87%	0.00%		100.00%

Other Conditions

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Epilepsy: QOF prevalence (18+)	2014/15	0.8%	0.9%	0.8%	0.1%		5.6%
EP002: Seizure free for last 12mths (den.incl.exc.) - retired	2013/14	29.4%	56.1%	61.2%	0.0%		100%
EP003: Contraception, conception and pregnancy (den.incl.exc.) - retired (Female)	2013/14	0.0%	39.6%	56.9%	0.0%		100%
Learning disability: QOF prevalence	2014/15	0.5%	0.5%	0.4%	0.0%		4.3%
LD002: Down's Syndrome with blood TSH record (den.incl.exc.) - retired	2013/14	-	48.2%	54.7%	0.0%		100%
% reporting learning difficulty	2014/15	1.8%	2.9%	2.6%	0.3%		30.8%
Hypothyroidism: QOF prevalence (all ages) - retired	2013/14	2.4%	3.8%	3.3%	0.0%		10.8%
THY002: function test recorded last 12mths (den.incl.exc.) - retired	2013/14	93.7%	92.9%	93.6%	0.0%		100%
Palliative/supportive care: QOF prevalence (all ages)	2014/15	0.4%	0.3%	0.3%	0.0%		35.3%
% reporting blindness or severe visual impairment	2014/15	-	1.4%	1.4%	0.3%		17.2%
% reporting deafness or severe hearing impairment	2014/15	0.6%	4.9%	4.0%	0.2%		17.2%

Public Health England

NATIONAL GENERAL PRACTICE PROFILES

PROFILE FOR

St.Barnabas Surgery

St.Barnabas Terrace, Stoke, Plymouth

These profiles are designed to support clinical commissioning groups (CCGs), GPs and local authorities to ensure that they are providing and commissioning effective and appropriate healthcare services for their local population. The tool presents a range of practice-level indicators drawn from the latest available data, including:

- local demography;
- Quality and Outcomes Framework (QOF) domains;
- patient satisfaction survey;
- cancer services

In addition to displaying individual practice profiles, the web tool allows you to view summary profiles for CCGs. Each practice can be compared with its CCG and with England, and also with the practices in the same deprivation deciles.

The profiles do not provide an exhaustive list of primary care indicators, but they do allow a consistent approach to comparing and benchmarking across England.

Note: QOF indicators are calculated as percent of patients receiving an intervention.

The profiles have been designed as a web tool and the full functionality and various chart types such as scatter plots and trend charts are only available via the web version. For more information consult the User guide and FAQs via the Supporting documents link, and for full metadata view the 'Definitions' on the website.

The development of this tool has been led by the Public Health England Fingertips team. For further information contact: ProfileFeedback@phe.gov.uk

Registered Persons	
St.Barnabas Surgery	1,709
NHS Northern, Eastern And Western Devon CCG	7,366 (average)
England	7,324 (average)

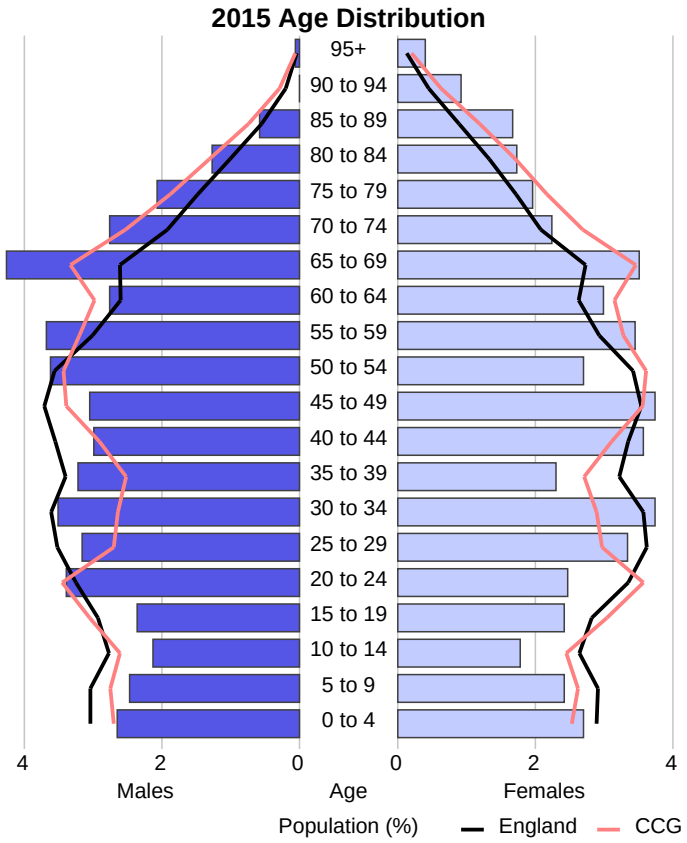
Deprivation

Third more deprived decile

QOF achievement	532.9 (out of 559)
Male life expectancy	75.2 years
Female life expectancy	79.9 years
% of patients that would recommend their practice	86.5%

Ethnicity Estimate

2.0% mixed, 2.3% asian, 1.4% black



http://fingertips.phe.org.uk/profile/general-practice

How to read the indicator spine charts

The light grey bar shows the range of values found in England. The dark grey sections mark out the range within which the middle half of the observed values lie (25th to 75th percentile).

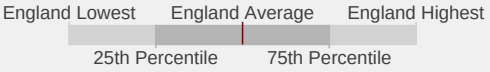
The red line shows where the England average is. The position of the circle shows the practice value, a triangle the CCG value, in relation to this scale.

The corresponding numbers can be found in the cells next to the chart.

If significance has been calculated for the indicator, then it is determined by whether the practice value is significantly higher or lower than the England average usually using 99.8% confidence intervals.

- No significant difference from England average
- Significantly different from England average
- Significance not calculated

- ○ Practice
- ▽ Clinical Commissioning Group



Practice Summary

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
% aged 0 to 4 years	2015	5.3%	5.2%	5.9%	0.0%		17.3%
% aged 5 to 14 years	2015	8.8%	10.4%	11.4%	0.0%		30.3%
% aged under 18 years	2015	17.0%	19.3%	20.7%	0.0%		53.5%
% aged 65+ years	2015	23.4%	22.2%	17.1%	0.0%		92.5%
% aged 75+ years	2015	10.6%	10.2%	7.8%	0.0%		79.6%
% aged 85+ years	2015	3.6%	3.1%	2.3%	0.0%		48.2%
Deprivation score (IMD 2015)	2015	31.1	19.9	21.8	3.2		66.5
Deprivation score (IMD 2010)	2012	30.0	19.8	21.5	2.9		68.4
IDACI (Income Depr. - Children)	2015	22.8%	16.1%	19.9%	1.4%		59.3%
IDAOPI (Income Depr. - Older People)	2015	21.8%	13.6%	16.2%	3.9%		65.3%
% who would recommend practice	2014/15	86.5%	85.6%	77.5%	15.2%		100%
% satisfied with phone access	2014/15	95.1%	84.4%	73.3%	11.9%		100%
% satisfied with opening hours	2014/15	85.5%	77.5%	74.9%	38.7%		100%
% who saw/spoke to nurse or GP same or next day	2014/15	49.7%	49.3%	48.3%	6.5%		98.3%
% reporting good overall experience of making appointment	2014/15	86.2%	83.3%	73.3%	16.8%		100%
% who know how to contact an out-of-hours GP service	2014/15	69.0%	66.1%	56.4%	11.9%		87.3%
% with a long-standing health condition	2014/15	55.9%	56.5%	54.0%	11.9%		94.7%
% with caring responsibility	2014/15	15.2%	19.2%	18.2%	0.5%		36.9%
Working status - Paid work or full-time education	2014/15	45.7%	59.1%	61.5%	8.5%		100%
Working status - Unemployed	2014/15	4.3%	4.0%	5.4%	0.4%		53.6%
Total QOF points	2014/15	95.3%	95.1%	94.8%	28.2%		100%
Life expectancy - MSOA based (Male)	2008 - 12	75.2	79.6	78.9	70.0		90.1
Life expectancy - MSOA based (Female)	2008 - 12	79.9	83.4	82.8	75.9		91.9
Nursing home patients	2014/15	2.3%	0.7%	0.5%	0.0%		14.9%

Cancer

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Cancer: QOF prevalence (all ages)	2014/15	3.7%	2.7%	2.3%	0.0%		6.2%
Exception rate for cancer indicator	2014/15	30.8%	17.1%	15.4%	0.0%		100%
New cancer cases (Crude incidence rate: new cases per 100,000 population)	2012/13	639	631	508	0		1593
% reporting cancer in the last 5 years	2014/15	4.5%	3.8%	3.3%	0.3%		11.9%
CAN003: review within 6 mths of diagnosis	2014/15	69.2%	79.4%	80.1%	0.0%		100%
Exception rate for the cervical screening indicator	2014/15	9.5%	5.2%	6.2%	0.0%		62.2%
CS002: Women, aged 25-64, with a record of cervical screening (last 5 yrs) (Female)	2014/15	68.5%	78.0%	76.7%	0.0%		100%
Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %) (Female)	2014/15	73.2%	76.9%	73.5%	0.0%		100%
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (Female)	2014/15	77.5%	78.1%	72.2%	0.0%		94.1%
Females, 50-70, screened for breast cancer within 6 months of invitation (Uptake, %) (Female)	2014/15	75.8%	77.1%	72.8%	0.0%		100%
Persons, 60-69, screened for bowel cancer within 6 months of invitation (Uptake, %)	2014/15	68.3%	62.0%	57.6%	0.0%		100%
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	2014/15	65.7%	62.7%	57.9%	10.1%		100%
Two-week wait referrals (Indirectly age-sex standardised referral ratio)	2014/15	146	1	100	0		614
Number of new cancer cases treated (Detection rate: % of which resulted from a TWW referral)	2014/15	58.8%	53.3%	48.4%	0.0%		100%
Two-week wait referrals for suspected breast cancer (Number per 100,000 population)	2014/15	761	595	482	0		1645
Two-week wait referrals for suspected lower GI cancers (Number per 100,000 population)	2014/15	585	529	421	0		2176
Two-week wait referrals for suspected lung cancer (Number per 100,000 population)	2014/15	117.0	110.0	100.5	0.0		824.7
Two-week wait referrals for suspected skin cancer (Number per 100,000 population)	2014/15	1287	824	508	0		3465
In-patient or day-case colonoscopy procedures (Number per 100,000 population)	2014/15	1170	806	695	0		2105
In-patient or day-case sigmoidoscopy procedures (Number per 100,000 population)	2014/15	293	422	431	0		1922
In-patient or day-case upper GI endoscopy procedures (Number per 100,000 population)	2014/15	878	1053	1142	28		3576
Number of emergency admissions with cancer (Number per 100,000 population)	2014/15	936	549	539	6		2970
Number of emergency presentations (Number per 100,000 population)	2014/15	59	104	90	0		721
Number of other presentations (Number per 100,000 population)	2014/15	761	491	360	0		1186

CVD - Coronary heart disease

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
CHD: QOF prevalence (all ages)	2014/15	6.1%	3.9%	3.2%	0.0%		20.9%
Heart failure w LVD: QOF prevalence	2014/15	0.4%	0.2%	0.2%	0.0%		2.2%
Exception rate for CHD indicators (2014/15 indicators)	2014/15	6.2%	9.4%	8.4%	0.0%		66.7%
CHD002: Last BP reading in last 12mths is <=150/90 (den.incl.exc.)	2014/15	89.4%	87.3%	88.4%	0.0%		100%
CHD003: Last total cholesterol is <=5mmol/l (den. incl. exc.) - retired	2013/14	82.1%	70.3%	73.2%	0.0%		100%
CHD005: Record that aspirin, APT or ACT is taken (den. incl. exc.)	2014/15	96.2%	92.0%	91.7%	0.0%		100%
CHD007: CHD patients immunised against flu (den.incl.exc.)	2014/15	83.7%	80.1%	81.2%	0.0%		100%
CHD006: History of MI: treated with ACE-I (den. incl. exc.)	2014/15	77.8%	64.0%	69.1%	0.0%		100%

CVD - Stroke and TIA

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Stroke: QOF prevalence (all ages)	2014/15	3.5%	2.2%	1.7%	0.0%		20.3%
Exception rate for stroke indicators (2014/15 indicators)	2014/15	2.2%	10.4%	9.7%	0.0%		66.7%
Exception rate for PAD indicators (2014/15 indicators)	2014/15	2.2%	6.6%	5.8%	0.0%		73.9%
STIA003: Last BP reading is =150/90 (den. incl. exc.)	2014/15	91.5%	83.6%	84.3%	0.0%		100%
STIA004: Total cholesterol recorded in last 15mths (den. incl. exc.) - retired	2013/14	88.3%	82.6%	84.5%	0.0%		100%
STIA005: Last measured total cholesterol <=5mmol/l (den. incl. exc.) - retired	2013/14	81.5%	64.4%	68.4%	0.0%		100%
STIA007: Record that an anti-platelet agent or an anti-coagulant is taken (den. incl. exc.)	2014/15	100%	92.9%	91.7%	0.0%		100%
STIA008: New patients referred for further investigation (den.incl.exc.)	2014/15	100%	75.0%	76.6%	0.0%		100%
STIA009: Influenza immunisation given 1 Aug-31 Mar (den.incl.exc.)	2014/15	83.1%	77.3%	77.5%	0.0%		100%
PAD002: last blood pressure reading (last 12 mnths) <=150/90 mmHg (den.incl.exc.)	2014/15	82.6%	84.0%	85.6%	0.0%		100%
PAD003: last total cholesterol measurement (last 12 mnths) <= 5.0 mmol/l (den.incl.exc.) - retired	2013/14	84.6%	66.1%	69.4%	0.0%		100%
PAD004: record of aspirin being taken (last 12 mnth) (den.incl.exc.)	2014/15	100%	88.1%	86.4%	0.0%		100%

CVD - Heart failure and atrial fibrillation

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Heart Failure: QOF prevalence (all ages)	2014/15	0.9%	0.8%	0.7%	0.0%		6.0%
Heart failure w LVD: QOF prevalence	2014/15	0.4%	0.2%	0.2%	0.0%		2.2%
Exception rate for heart failure indicators	2014/15	3.7%	12.5%	9.2%	0.0%		78.0%
Atrial fibrillation: QOF prevalence	2014/15	1.8%	2.2%	1.6%	0.0%		14.1%
Estimated prevalence of Atrial Fibrillation	2013/14	3.3%	3.0%	2.4%	0.0%		16.7%
Estimated prevalence of Atrial Fibrillation (Male)	2013/14	3.4%	3.5%		0.1%		17.2%
Estimated prevalence of Atrial Fibrillation (Female)	2013/14	3.2%	2.5%		0.0%		16.4%
Estimated percentage of detected Atrial Fibrillation	2013/14	65.5	68.9	65.2	0.0		131.9
Exception rate for atrial fibrillation indicators (2014/15 indicators)	2014/15	5.6%	11.4%	11.0%	0.0%		100%
HF002: Diagnosis conf. by ECG/specialist assessm. (den. incl. exc.)	2014/15	84.6%	88.1%	90.9%	0.0%		100%
HF003: Heart failure w LVD: treated with ACE-I or ARB (den. incl. exc.)	2014/15	100%	83.1%	86.0%	0.0%		100%
HF004: Heart failure w LVD: treatment w ACE inh. or ARB, and beta-blocker (den.incl.exc.)	2014/15	100%	70.3%	76.3%	0.0%		100%
AF002: stroke risk assessed with CHADS2 (last 12 mnths) (den.incl.exc.) - retired	2013/14	96.2%	92.7%	95.0%	0.0%		100%
AF004: treated w anti-coag. therapy (CHADS2 >1) (den.incl.exc.)	2014/15	93.8%	77.0%	74.3%	0.0%		100%
AF005: treated w anti-coag./platelet therapy (if CHADS2 =1) (den.incl.exc.)	2014/15	100%	92.4%	92.2%	0.0%		100%

CVD - Risk factors for CVD

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Hypertension: QOF prevalence (all ages)	2014/15	15.4%	15.2%	13.8%	0.1%		47.6%
Exception rate for hypertension indicator (2014/15)	2014/15	1.1%	5.0%	3.8%	0.0%		46.9%
Exception rate for the BP indicator	2014/15	1.4%	0.6%	0.4%	0.0%		49.9%
Obesity: QOF prevalence (16+)	2014/15	1.9%	10.1%	9.0%	0.0%		29.4%
Estimated smoking prevalence (QOF)	2014/15	22.3	17.3	18.4	0.0		83.3
Exception rate for smoking indicators (2014/15 indicators)	2014/15	2.0%	1.3%	1.0%	0.0%		65.0%
GP patient survey: smoking prevalence	2014/15	15.3%	15.6%	16.4%	1.3%		85.8%
GP patient survey: ex-smoking prevalence	2014/15	36.4%	30.6%	27.4%	0.5%		51.3%
SMOK001: record of smoking status in last 24 months (15+ y), den. incl. exc. - retired	2013/14	85.5%	83.2%	85.6%	2.1%		100%
SMOK002: status recorded in last 12 mths (certain conditions), den.incl.exc.	2014/15	92.3%	93.5%	93.2%	0.0%		100%
SMOK004: record of offer of support and treatment (15+, last 24 mnths), den. incl. exc.	2014/15	86.8%	84.9%	85.8%	0.0%		100%
SMOK005: cessation support and treatment offered (certain conditions), den. incl. exc.	2014/15	98.0%	93.3%	94.1%	12.6%		100%
HYP006: Blood pressure <= 150/90 mmHg in people with hypertension	2014/15	87.5%	80.2%	80.4%	0.0%		100%
HYP003: Last (9mnths) blood pressure <= 140/90 mmHg (age <80) (den.incl.exc.) - retired	2013/14	75.5%	64.1%	70.4%	0.0%		98.9%
HYP004: Phys. act. assessment (last 12 mnths), patients with hypertension aged 16-74 (den.incl.exc.) - retired	2013/14	76.5%	62.5%	76.0%	0.0%		100%
HYP005: Patients w. hypertension who had a phys. act. assessment and where found to be inactive who had also a brief intervention (both in last 12mnths, aged 16-74) (den.incl.exc.) - retired	2013/14	69.7%	78.4%	86.3%	0.0%		100%
BP002: Patients, aged 45+, who have a record of blood pressure (last 5yrs)	2014/15	91.4%	91.1%	90.6%	0.0%		100%
CVD-PP001: new hypertension patients, age 30-74, with CV risk assessment >=20% treated w. statins (den.incl.exc.)	2014/15	-	65.5%	67.7%	0.0%		100%
CVD-PP002: Lifestyle advice for patients with hypertension (den. incl. exc.) - retired	2013/14	68.2%	66.4%	79.0%	0.0%		100%

Child health

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
% aged 0 to 4 years	2015	5.3%	5.2%	5.9%	0.0%		17.3%
% aged 5 to 14 years	2015	8.8%	10.4%	11.4%	0.0%		30.3%
% aged under 18 years	2015	17.0%	19.3%	20.7%	0.0%		53.5%
IDACI (Income Depr. - Children)	2015	22.8%	16.1%	19.9%	1.4%		59.3%
A&E attendances (0-4)	2011/12 - 13/14	204	471	530	22		2705
A&E attendances (5-17)	2011/12 - 13/14	211	301	307	5		1145
A&E attendances (<18)	2011/12 - 13/14	209	347	373	11		1504
Elective hospital admissions for all causes (<18)	2011/12 - 13/14	30.5	47.7	49.0	1.6		249.1
Emergency hospital admissions for all causes (<18)	2011/12 - 13/14	63.4	65.8	69.5	2.5		270.0
Emergency respiratory admissions (<18)	2009/10 - 13/14	-	3.8	3.8	0.4		14.5
Emergency gastroenteritis admissions (0-4)	2009/10 - 13/14	20.8	11.4	11.3	0.8		72.1
Emergency admissions for asthma, diabetes or epilepsy (<18)	2009/10 - 13/14	-	3.0	3.4	0.4		54.7
Admissions due to injury (<18)	2011/12 - 13/14	-	10.6	11.1	0.7		52.8
Outpatient first attendances (<18)	2011/12 - 13/14	263	282	246	6		1144
Ratio of first to follow-up outpatient attendances (<18)	2011/12 - 13/14	0.38	0.46	0.51	0.20		2.14
DNA rate for outpatient appointments (<18)	2011/12 - 13/14	7.5%	10.7%	11.5%	0.6%		32.3%

Chronic Kidney Disease

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
CKD: QOF prevalence (18+)	2014/15	8.2%	4.9%	4.1%	0.0%		23.8%
Exception rate for CKD indicators	2014/15	3.1%	9.5%	7.5%	0.0%		60.0%
CKD002: Last BP reading measured in last 12mths is <=140/85 (den. incl. exc.)	2014/15	80.3%	71.1%	74.4%	0.0%		100%
CKD003: Hypertension treated with ACE inhibitor/ARB (den. incl. exc.)	2014/15	91.3%	76.0%	76.4%	0.0%		100%
CKD004: Urine albumin:creatinine ratio test last 12 mths (den. incl. exc.)	2014/15	76.9%	75.8%	75.4%	0.0%		100%

Diabetes

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Diabetes: QOF prevalence (17+)	2014/15	8.0%	6.5%	6.4%	0.3%		20.4%
Exception rate for diabetes indicators (2014/15 indicators)	2014/15	10.1%	12.6%	10.8%	0.0%		49.0%
Hypertension: QOF prevalence (all ages)	2014/15	15.4%	15.2%	13.8%	0.1%		47.6%
Exception rate for hypertension indicator (2014/15)	2014/15	1.1%	5.0%	3.8%	0.0%		46.9%
Exception rate for smoking indicators (2014/15 indicators)	2014/15	2.0%	1.3%	1.0%	0.0%		65.0%
Obesity: QOF prevalence (16+)	2014/15	1.9%	10.1%	9.0%	0.0%		29.4%
DM007: Last HbA1c is <=59mmol/mol in last 12mths (den. incl. exc.)	2014/15	67.2%	60.3%	60.4%	0.0%		100%
DM008: Last HbA1c is <=64mmol/mol in last 12mths (den. incl. exc.)	2014/15	70.7%	68.7%	68.4%	0.0%		100%
DM009: Last HbA1c is <=75mmol/mol in last 12mths (den. incl. exc.)	2014/15	77.6%	80.4%	79.3%	0.0%		100%
DM002: Last BP is <=150/90 (den. incl. exc.)	2014/15	92.2%	85.4%	86.6%	0.0%		100%
DM003: Last BP is <=140/80 (den. incl. exc.)	2014/15	85.3%	67.2%	71.2%	0.0%		100%
DM004: Measured total cholesterol (last 12mths) <=5mmol/l(den.incl.exc.)	2014/15	82.8%	70.2%	70.8%	0.0%		100%
DM005: Record of micro-albuminuria test last 12mths (den. incl. exc.) - retired	2013/14	78.0%	76.7%	80.6%	1.1%		100%
DM006: Proteinuria/micro-album. treated w inhibitors (den. incl. exc.)	2014/15	92.9%	79.2%	81.2%	0.0%		100%
DM011: record of retinal screening (den.incl.exc.) - retired	2013/14	69.9%	77.4%	82.6%	0.0%		100%
DM012: Patients with diabetes who had a foot examination and risk classification (den.incl.exc.)	2014/15	75.0%	81.7%	81.5%	0.0%		100%
DM013: Patients with diabetes who had a dietary review (last 12mths) (den.incl.exc.) - retired	2013/14	57.7%	75.9%	82.2%	0.0%		100%
DM014: Newly diagnosed patients w. diabetes referred to education programme within 9 mths (den.incl.exc.)	2014/15	16.7%	49.6%	66.3%	0.0%		100%
DM015: Male patients w. diabetes asked about erectile disfunction (last 12 mths) (den.incl.exc.) - retired (Male)	2013/14	77.3%	69.8%	81.6%	0.0%		100%
DM016: Male patients w. diabetes w. erectile disfunction who got advice (den.incl.exc.) - retired (Male)	2013/14	50.0%	77.8%	87.9%	0.0%		100%
DM018: Flu vaccination coverage (den.incl.exc.)	2014/15	73.3%	76.4%	77.6%	37.0%		100%

Mental Health

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Mental Health: QOF prevalence (all ages)	2014/15	1.99%	0.85%	0.88%	0.06%		15.57%
Exception rate for MH indicators (2014/15 indicators)	2014/15	8.3%	11.8%	11.1%	0.0%		76.7%
Dementia: QOF prevalence (all ages)	2014/15	2.0%	0.9%	0.7%	0.0%		59.2%
% reporting Alzheimer's disease or dementia	2014/15	2.1%	0.9%	1.0%	0.3%		25.0%
Exception rate for dementia indicators	2014/15	2.6%	9.8%	8.3%	0.0%		100%
Depression: QOF incidence (18+) - new diagnosis	2014/15	2.0	1.3	1.2	0.0		18.2
Depression: QOF prevalence (18+)	2014/15	14.6%	8.1%	7.3%	0.0%		33.0%
Exception rate for depression indicator (2014/15 indicators)	2014/15	37.9%	25.5%	24.5%	0.0%		100%
% reporting a long-term mental health problem	2014/15	9.4%	4.8%	5.1%	0.4%		60.1%
MH002: comprehensive care plan (den. incl. exc.)	2014/15	85.7%	74.7%	77.2%	0.0%		100%
MH007: record of alcohol consumption for patients on the MH register (last 12 mnths), den. incl. exc.	2014/15	67.9%	77.1%	80.3%	0.0%		100%
MH006: record of BMI for patients on the MH register in preceding 12 months (den.incl.exc.) - retired	2013/14	87.1%	75.3%	78.8%	0.0%		100%
MH003: record of blood pressure check in preceding 12 months for patients on the MH register (den.incl.exc.)	2014/15	71.4%	79.7%	81.5%	0.0%		100%
MH008: Female patients (25-64 yrs) on the MH register who had cervical screening test in preceding 5 years (den. incl. exc.)	2014/15	50.0%	71.5%	71.6%	0.0%		100%
MH009: Patients on lithium therapy with record of serum creatinine and TSH in the preceding 9 months (den.incl.exc.)	2014/15	100%	93.9%	93.4%	0.0%		100%
MH010: Patients on lithium therapy with levels in therapeutic range in preceding 4 months (den.incl.exc.)	2014/15	66.7%	84.0%	82.6%	0.0%		100%
MH004: Patients on MH register with cholesterol check in preceding 12 months (den.incl.exc.) - retired	2013/14	80.0%	61.4%	68.0%	0.0%		100%
MH005: Patients on the MH register with blood glucose or HbA1c check in preceding 12 months (den.incl.exc.) - retired	2013/14	76.2%	71.0%	74.9%	0.0%		100%
DEP001: Newly diagnosed patients w. depression who had a bio-psychosocial assessment on diagnosis (current FY, aged 18+) (den.incl.exc.) - retired	2013/14	80.0%	68.3%	75.8%	0.0%		100%
DEP003: Newly diagnosed patients with depression who had a review 10-56 days after diagnosis (den.incl.exc.)	2014/15	58.6%	63.4%	63.8%	0.0%		100%
DEM002: Dementia care has been reviewed last 12mths (den.incl.exc.)	2014/15	73.5%	77.9%	77.0%	0.0%		100%
DEM003: Blood tests recorded (den.incl.exc.)	2014/15	100%	73.1%	74.7%	0.0%		100%

Musculoskeletal Conditions

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Osteoporosis: QOF prevalence (50+)	2014/15	0.5	0.2	0.2	0.0		9.6
Exception rate for OST indicators	2014/15	0.0%	13.0%	12.5%	0.0%		100%
Rheumatoid Arthritis: QOF prevalence (16+)	2014/15	0.55	0.82	0.73	0.00		4.60
Exception rate for RA indicators (2014/15 indicators)	2014/15	12.5%	8.4%	7.4%	0.0%		82.8%
% reporting a long-term back problem	2014/15	11.7%	9.6%	9.9%	0.0%		38.4%
% reporting arthritis or long-term joint problem	2014/15	16.4%	13.4%	12.8%	0.4%		34.9%
OST002: currently treated with a bone-sparing agent (50-74 yrs)(den.incl.exc.)	2014/15	100%	82.7%	82.8%	0.0%		100%
OST005: Patients (75+ yrs) with a fragility fracture treated with bone-sparing agent (den.incl.exc.)	2014/15	100%	78.4%	79.3%	0.0%		100%
RA002: Patients with rheumatoid arthritis who had a face-to-face review (last 12 mnths) (den.incl.exc.)	2014/15	37.5%	84.7%	84.3%	0.0%		100%
RA003: Patients w. rheumatoid arthritis, aged 30-84, who had an RA adjusted CV risk assessment (last 12 mnths) (den.incl.exc.) - retired	2013/14	100%	75.0%	86.8%	0.0%		100%
RA004: Patients w. rheumatoid arthritis, aged 50-90, who had an RA adjusted fracture risk assessment (last 24 mnths) (den.incl.exc.) - retired	2013/14	100%	68.5%	82.1%	0.0%		100%

Respiratory Disease

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
COPD: QOF prevalence (all ages)	2014/15	2.4%	2.0%	1.8%	0.0%		9.0%
Exception rate for COPD indicators	2014/15	13.1%	12.6%	12.3%	0.0%		57.8%
Asthma: QOF prevalence (all ages)	2014/15	8.0%	6.7%	6.0%	0.7%		12.5%
Exception rate for asthma indicators	2014/15	4.2%	9.4%	6.8%	0.0%		63.7%
Estimated smoking prevalence (QOF)	2014/15	22.3	17.3	18.4	0.0		83.3
Exception rate for smoking indicators (2014/15 indicators)	2014/15	2.0%	1.3%	1.0%	0.0%		65.0%
GP patient survey: smoking prevalence	2014/15	15.3%	15.6%	16.4%	1.3%		85.8%
GP patient survey: ex-smoking prevalence	2014/15	36.4%	30.6%	27.4%	0.5%		51.3%
COPD007: Influenza immunisation given 1 Aug - 31 Mar (den. incl. exc.)	2014/15	85.4%	80.8%	81.5%	0.0%		100%
COPD004: Record of FEV1 in last 12mths (den. incl. exc.)	2014/15	78.0%	75.8%	73.2%	0.0%		100%
COPD003: assessed using MRC dyspnoea score last 12mths (den. incl. exc.)	2014/15	75.6%	79.5%	79.9%	0.0%		100%
COPD002: Diagnosis conf. by spirometry (den. incl. exc.)	2014/15	80.0%	79.5%	81.1%	0.0%		100%
AST002: with measures of variability/reversibility (8+), den. incl. exc.	2014/15	88.9%	83.6%	84.3%	0.0%		100%
AST003: review in the last 12 months (incl. an assessment using the 3 RCP questions), den. incl. exc.	2014/15	70.6%	67.8%	69.7%	0.0%		100%
AST004: smoking recorded in last 12 mths (14-19y w asthma), den. incl. exc.	2014/15	80.0%	81.2%	83.9%	0.0%		100%
SMOK002: status recorded in last 12 mths (certain conditions), den.incl.exc.	2014/15	92.3%	93.5%	93.2%	0.0%		100%
SMOK005: cessation support and treatment offered (certain conditions), den. incl. exc.	2014/15	98.0%	93.3%	94.1%	12.6%		100%
SMOK001: record of smoking status in last 24 months (15+ y), den. incl. exc. - retired	2013/14	85.5%	83.2%	85.6%	2.1%		100%
SMOK004: record of offer of support and treatment (15+, last 24 mnths), den. incl. exc.	2014/15	86.8%	84.9%	85.8%	0.0%		100%
COPD005: Patients w. MRC dyspnoea score >=3 w.oxygen saturation value (last 12mths) (den.incl.exc.)	2014/15	82.4%	94.6%	94.5%	0.0%		100%

AMR Local indicators

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Total number of prescribed antibiotic items per 1000 registered patients by quarter	2016 Q1	281.2	161.1	160.2	0.1		2119.7
Total number of prescribed antibiotic items per STAR-PU by quarter	2016 Q1	0.47	0.27	0.30	0.00		4.06
Percentage of broad spectrum prescribed antibiotic items (cephalosporin, quinolone and co-amoxiclav class) by quarter	2016 Q1	15.04%	10.96%	9.87%	0.00%		100.00%

Other Conditions

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Epilepsy: QOF prevalence (18+)	2014/15	1.7%	0.9%	0.8%	0.1%		5.6%
EP002: Seizure free for last 12mths (den.incl.exc.) - retired	2013/14	59.1%	56.1%	61.2%	0.0%		100%
EP003: Contraception, conception and pregnancy (den.incl.exc.) - retired (Female)	2013/14	33.3%	39.6%	56.9%	0.0%		100%
Learning disability: QOF prevalence	2014/15	2.2%	0.5%	0.4%	0.0%		4.3%
LD002: Down's Syndrome with blood TSH record (den.incl.exc.) - retired	2013/14	40.0%	48.2%	54.7%	0.0%		100%
% reporting learning difficulty	2014/15	3.2%	2.9%	2.6%	0.3%		30.8%
Hypothyroidism: QOF prevalence (all ages) - retired	2013/14	5.4%	3.8%	3.3%	0.0%		10.8%
THY002: function test recorded last 12mths (den.incl.exc.) - retired	2013/14	94.7%	92.9%	93.6%	0.0%		100%
Palliative/supportive care: QOF prevalence (all ages)	2014/15	0.1%	0.3%	0.3%	0.0%		35.3%
% reporting blindness or severe visual impairment	2014/15	2.9%	1.4%	1.4%	0.3%		17.2%
% reporting deafness or severe hearing impairment	2014/15	2.8%	4.9%	4.0%	0.2%		17.2%

Public Health England

NATIONAL GENERAL PRACTICE PROFILES

PROFILE FOR

Saltash Road Surgery

218 Saltash Road, Keyham, Plymouth, Devon

These profiles are designed to support clinical commissioning groups (CCGs), GPs and local authorities to ensure that they are providing and commissioning effective and appropriate healthcare services for their local population. The tool presents a range of practice-level indicators drawn from the latest available data, including:

- local demography;
- Quality and Outcomes Framework (QOF) domains;
- patient satisfaction survey;
- cancer services

In addition to displaying individual practice profiles, the web tool allows you to view summary profiles for CCGs. Each practice can be compared with its CCG and with England, and also with the practices in the same deprivation deciles.

The profiles do not provide an exhaustive list of primary care indicators, but they do allow a consistent approach to comparing and benchmarking across England.

Note: QOF indicators are calculated as percent of patients receiving an intervention.

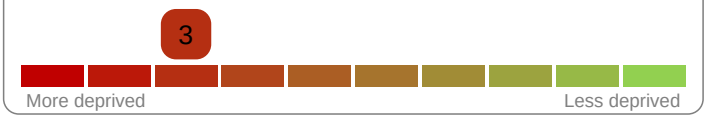
The profiles have been designed as a web tool and the full functionality and various chart types such as scatter plots and trend charts are only available via the web version. For more information consult the User guide and FAQs via the Supporting documents link, and for full metadata view the 'Definitions' on the website.

The development of this tool has been led by the Public Health England Fingertips team. For further information contact: ProfileFeedback@phe.gov.uk

Registered Persons	
Saltash Road Surgery	2,091
NHS Northern, Eastern And Western Devon CCG	7,366 (average)
England	7,324 (average)

Deprivation

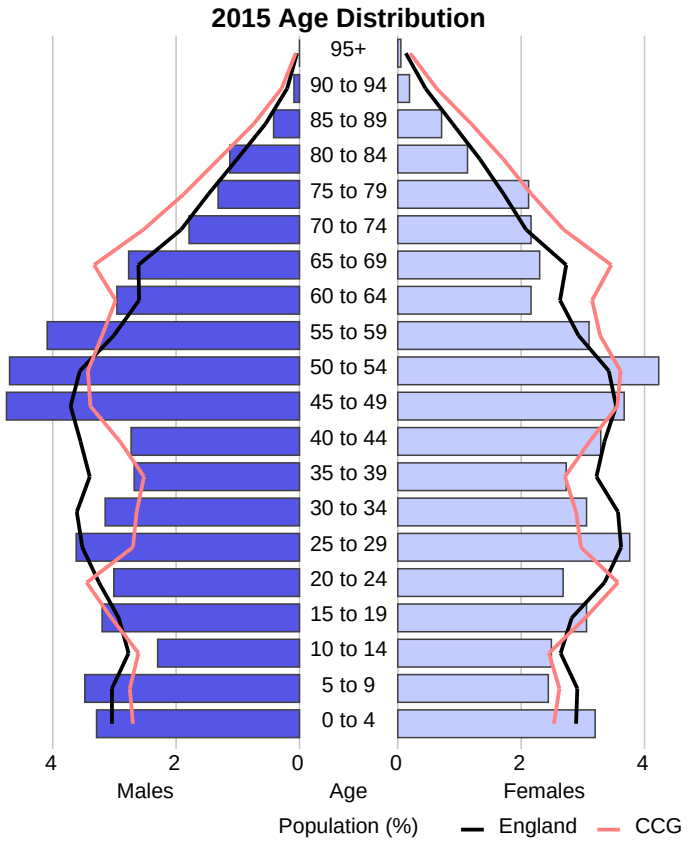
Third more deprived decile



QOF achievement	428.2 (out of 559)
Male life expectancy	77.4 years
Female life expectancy	80.3 years
% of patients that would recommend their practice	76.8%

Ethnicity Estimate

1.3% mixed, 1.0% asian, 1.1% other non-white ethnic groups



http://fingertips.phe.org.uk/profile/general-practice

How to read the indicator spine charts

The light grey bar shows the range of values found in England. The dark grey sections mark out the range within which the middle half of the observed values lie (25th to 75th percentile).

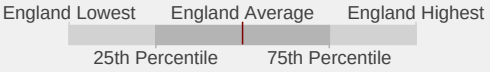
The red line shows where the England average is. The position of the circle shows the practice value, a triangle the CCG value, in relation to this scale.

The corresponding numbers can be found in the cells next to the chart.

If significance has been calculated for the indicator, then it is determined by whether the practice value is significantly higher or lower than the England average usually using 99.8% confidence intervals.

- No significant difference from England average
- Significantly different from England average
- Significance not calculated

- ○ Practice
- ▽ Clinical Commissioning Group



Practice Summary

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
% aged 0 to 4 years	2015	6.5%	5.2%	5.9%	0.0%		17.3%
% aged 5 to 14 years	2015	10.7%	10.4%	11.4%	0.0%		30.3%
% aged under 18 years	2015	21.0%	19.3%	20.7%	0.0%		53.5%
% aged 65+ years	2015	16.2%	22.2%	17.1%	0.0%		92.5%
% aged 75+ years	2015	7.1%	10.2%	7.8%	0.0%		79.6%
% aged 85+ years	2015	1.5%	3.1%	2.3%	0.0%		48.2%
Deprivation score (IMD 2015)	2015	33.6	19.9	21.8	3.2		66.5
Deprivation score (IMD 2010)	2012	32.3	19.8	21.5	2.9		68.4
IDACI (Income Depr. - Children)	2015	30.8%	16.1%	19.9%	1.4%		59.3%
IDAOPI (Income Depr. - Older People)	2015	22.5%	13.6%	16.2%	3.9%		65.3%
% who would recommend practice	2014/15	76.8%	85.6%	77.5%	15.2%		100%
% satisfied with phone access	2014/15	82.2%	84.4%	73.3%	11.9%		100%
% satisfied with opening hours	2014/15	76.3%	77.5%	74.9%	38.7%		100%
% who saw/spoke to nurse or GP same or next day	2014/15	76.7%	49.3%	48.3%	6.5%		98.3%
% reporting good overall experience of making appointment	2014/15	71.4%	83.3%	73.3%	16.8%		100%
% who know how to contact an out-of-hours GP service	2014/15	64.9%	66.1%	56.4%	11.9%		87.3%
% with a long-standing health condition	2014/15	59.7%	56.5%	54.0%	11.9%		94.7%
% with caring responsibility	2014/15	22.7%	19.2%	18.2%	0.5%		36.9%
Working status - Paid work or full-time education	2014/15	50.8%	59.1%	61.5%	8.5%		100%
Working status - Unemployed	2014/15	8.0%	4.0%	5.4%	0.4%		53.6%
Total QOF points	2014/15	76.6%	95.1%	94.8%	28.2%		100%
Life expectancy - MSOA based (Male)	2008 - 12	77.4	79.6	78.9	70.0		90.1
Life expectancy - MSOA based (Female)	2008 - 12	80.3	83.4	82.8	75.9		91.9
Nursing home patients	2014/15	0.1%	0.7%	0.5%	0.0%		14.9%

Cancer

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Cancer: QOF prevalence (all ages)	2014/15	1.5%	2.7%	2.3%	0.0%		6.2%
Exception rate for cancer indicator	2014/15	50.0%	17.1%	15.4%	0.0%		100%
New cancer cases (Crude incidence rate: new cases per 100,000 population)	2012/13	556	631	508	0		1593
% reporting cancer in the last 5 years	2014/15	2.0%	3.8%	3.3%	0.3%		11.9%
CAN003: review within 6 mths of diagnosis	2014/15	50.0%	79.4%	80.1%	0.0%		100%
Exception rate for the cervical screening indicator	2014/15	5.3%	5.2%	6.2%	0.0%		62.2%
CS002: Women, aged 25-64, with a record of cervical screening (last 5 yrs) (Female)	2014/15	72.9%	78.0%	76.7%	0.0%		100%
Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %) (Female)	2014/15	72.4%	76.9%	73.5%	0.0%		100%
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (Female)	2014/15	76.8%	78.1%	72.2%	0.0%		94.1%
Females, 50-70, screened for breast cancer within 6 months of invitation (Uptake, %) (Female)	2014/15	76.5%	77.1%	72.8%	0.0%		100%
Persons, 60-69, screened for bowel cancer within 6 months of invitation (Uptake, %)	2014/15	59.8%	62.0%	57.6%	0.0%		100%
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	2014/15	57.0%	62.7%	57.9%	10.1%		100%
Two-week wait referrals (Indirectly age-sex standardised referral ratio)	2014/15	113	1	100	0		614
Number of new cancer cases treated (Detection rate: % of which resulted from a TWW referral)	2014/15	30.8%	53.3%	48.4%	0.0%		100%
Two-week wait referrals for suspected breast cancer (Number per 100,000 population)	2014/15	622	595	482	0		1645
Two-week wait referrals for suspected lower GI cancers (Number per 100,000 population)	2014/15	143	529	421	0		2176
Two-week wait referrals for suspected lung cancer (Number per 100,000 population)	2014/15	47.8	110.0	100.5	0.0		824.7
Two-week wait referrals for suspected skin cancer (Number per 100,000 population)	2014/15	1243	824	508	0		3465
In-patient or day-case colonoscopy procedures (Number per 100,000 population)	2014/15	670	806	695	0		2105
In-patient or day-case sigmoidoscopy procedures (Number per 100,000 population)	2014/15	383	422	431	0		1922
In-patient or day-case upper GI endoscopy procedures (Number per 100,000 population)	2014/15	813	1053	1142	28		3576
Number of emergency admissions with cancer (Number per 100,000 population)	2014/15	430	549	539	6		2970
Number of emergency presentations (Number per 100,000 population)	2014/15	143	104	90	0		721
Number of other presentations (Number per 100,000 population)	2014/15	239	491	360	0		1186

CVD - Coronary heart disease

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
CHD: QOF prevalence (all ages)	2014/15	3.5%	3.9%	3.2%	0.0%		20.9%
Heart failure w LVD: QOF prevalence	2014/15	0.0%	0.2%	0.2%	0.0%		2.2%
Exception rate for CHD indicators (2014/15 indicators)	2014/15	3.2%	9.4%	8.4%	0.0%		66.7%
CHD002: Last BP reading in last 12mths is <=150/90 (den.incl.exc.)	2014/15	83.6%	87.3%	88.4%	0.0%		100%
CHD003: Last total cholesterol is <=5mmol/l (den. incl. exc.) - retired	2013/14	64.9%	70.3%	73.2%	0.0%		100%
CHD005: Record that aspirin, APT or ACT is taken (den. incl. exc.)	2014/15	93.2%	92.0%	91.7%	0.0%		100%
CHD007: CHD patients immunised against flu (den.incl.exc.)	2014/15	84.9%	80.1%	81.2%	0.0%		100%
CHD006: History of MI: treated with ACE-I (den. incl. exc.)	2014/15	66.7%	64.0%	69.1%	0.0%		100%

CVD - Stroke and TIA

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Stroke: QOF prevalence (all ages)	2014/15	1.5%	2.2%	1.7%	0.0%		20.3%
Exception rate for stroke indicators (2014/15 indicators)	2014/15	11.4%	10.4%	9.7%	0.0%		66.7%
Exception rate for PAD indicators (2014/15 indicators)	2014/15	2.3%	6.6%	5.8%	0.0%		73.9%
STIA003: Last BP reading is =150/90 (den. incl. exc.)	2014/15	71.9%	83.6%	84.3%	0.0%		100%
STIA004: Total cholesterol recorded in last 15mths (den. incl. exc.) - retired	2013/14	73.3%	82.6%	84.5%	0.0%		100%
STIA005: Last measured total cholesterol <=5mmol/l (den. incl. exc.) - retired	2013/14	61.5%	64.4%	68.4%	0.0%		100%
STIA007: Record that an anti-platelet agent or an anti-coagulant is taken (den. incl. exc.)	2014/15	91.7%	92.9%	91.7%	0.0%		100%
STIA008: New patients referred for further investigation (den.incl.exc.)	2014/15	-	75.0%	76.6%	0.0%		100%
STIA009: Influenza immunisation given 1 Aug-31 Mar (den.incl.exc.)	2014/15	71.9%	77.3%	77.5%	0.0%		100%
PAD002: last blood pressure reading (last 12 mnths) <=150/90 mmHg (den.incl.exc.)	2014/15	75.0%	84.0%	85.6%	0.0%		100%
PAD003: last total cholesterol measurement (last 12 mnths) <= 5.0 mmol/l (den.incl.exc.) - retired	2013/14	69.2%	66.1%	69.4%	0.0%		100%
PAD004: record of aspirin being taken (last 12 mnth) (den.incl.exc.)	2014/15	84.2%	88.1%	86.4%	0.0%		100%

CVD - Heart failure and atrial fibrillation

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Heart Failure: QOF prevalence (all ages)	2014/15	0.5%	0.8%	0.7%	0.0%		6.0%
Heart failure w LVD: QOF prevalence	2014/15	0.0%	0.2%	0.2%	0.0%		2.2%
Exception rate for heart failure indicators	2014/15	0.0%	12.5%	9.2%	0.0%		78.0%
Atrial fibrillation: QOF prevalence	2014/15	1.2%	2.2%	1.6%	0.0%		14.1%
Estimated prevalence of Atrial Fibrillation	2013/14	2.3%	3.0%	2.4%	0.0%		16.7%
Estimated prevalence of Atrial Fibrillation (Male)	2013/14	2.7%	3.5%		0.1%		17.2%
Estimated prevalence of Atrial Fibrillation (Female)	2013/14	1.9%	2.5%		0.0%		16.4%
Estimated percentage of detected Atrial Fibrillation	2013/14	46.9	68.9	65.2	0.0		131.9
Exception rate for atrial fibrillation indicators (2014/15 indicators)	2014/15	9.1%	11.4%	11.0%	0.0%		100%
HF002: Diagnosis conf. by ECG/specialist assessm. (den. incl. exc.)	2014/15	100%	88.1%	90.9%	0.0%		100%
HF003: Heart failure w LVD: treated with ACE-I or ARB (den. incl. exc.)	2014/15	-	83.1%	86.0%	0.0%		100%
HF004: Heart failure w LVD: treatment w ACE inh. or ARB, and beta-blocker (den.incl.exc.)	2014/15	-	70.3%	76.3%	0.0%		100%
AF002: stroke risk assessed with CHADS2 (last 12 mnths) (den.incl.exc.) - retired	2013/14	100%	92.7%	95.0%	0.0%		100%
AF004: treated w anti-coag. therapy (CHADS2 >1) (den.incl.exc.)	2014/15	85.7%	77.0%	74.3%	0.0%		100%
AF005: treated w anti-coag./platelet therapy (if CHADS2 =1) (den.incl.exc.)	2014/15	87.5%	92.4%	92.2%	0.0%		100%

CVD - Risk factors for CVD

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Hypertension: QOF prevalence (all ages)	2014/15	18.4%	15.2%	13.8%	0.1%		47.6%
Exception rate for hypertension indicator (2014/15)	2014/15	1.8%	5.0%	3.8%	0.0%		46.9%
Exception rate for the BP indicator	2014/15	0.3%	0.6%	0.4%	0.0%		49.9%
Obesity: QOF prevalence (16+)	2014/15	27.2%	10.1%	9.0%	0.0%		29.4%
Estimated smoking prevalence (QOF)	2014/15	27.4	17.3	18.4	0.0		83.3
Exception rate for smoking indicators (2014/15 indicators)	2014/15	1.1%	1.3%	1.0%	0.0%		65.0%
GP patient survey: smoking prevalence	2014/15	18.7%	15.6%	16.4%	1.3%		85.8%
GP patient survey: ex-smoking prevalence	2014/15	33.6%	30.6%	27.4%	0.5%		51.3%
SMOK001: record of smoking status in last 24 months (15+ y), den. incl. exc. - retired	2013/14	85.9%	83.2%	85.6%	2.1%		100%
SMOK002: status recorded in last 12 mths (certain conditions), den.incl.exc.	2014/15	93.2%	93.5%	93.2%	0.0%		100%
SMOK004: record of offer of support and treatment (15+, last 24 mnths), den. incl. exc.	2014/15	77.0%	84.9%	85.8%	0.0%		100%
SMOK005: cessation support and treatment offered (certain conditions), den. incl. exc.	2014/15	85.1%	93.3%	94.1%	12.6%		100%
HYP006: Blood pressure <= 150/90 mmHg in people with hypertension	2014/15	76.6%	80.2%	80.4%	0.0%		100%
HYP003: Last (9mnths) blood pressure <= 140/90 mmHg (age <80) (den.incl.exc.) - retired	2013/14	51.4%	64.1%	70.4%	0.0%		98.9%
HYP004: Phys. act. assessment (last 12 mnths), patients with hypertension aged 16-74 (den.incl.exc.) - retired	2013/14	83.0%	62.5%	76.0%	0.0%		100%
HYP005: Patients w. hypertension who had a phys. act. assessment and where found to be inactive who had also a brief intervention (both in last 12mnths, aged 16-74) (den.incl.exc.) - retired	2013/14	72.8%	78.4%	86.3%	0.0%		100%
BP002: Patients, aged 45+, who have a record of blood pressure (last 5yrs)	2014/15	95.5%	91.1%	90.6%	0.0%		100%
CVD-PP001: new hypertension patients, age 30-74, with CV risk assessment >=20% treated w. statins (den.incl.exc.)	2014/15	-	65.5%	67.7%	0.0%		100%
CVD-PP002: Lifestyle advice for patients with hypertension (den. incl. exc.) - retired	2013/14	57.1%	66.4%	79.0%	0.0%		100%

Child health

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
% aged 0 to 4 years	2015	6.5%	5.2%	5.9%	0.0%		17.3%
% aged 5 to 14 years	2015	10.7%	10.4%	11.4%	0.0%		30.3%
% aged under 18 years	2015	21.0%	19.3%	20.7%	0.0%		53.5%
IDACI (Income Depr. - Children)	2015	30.8%	16.1%	19.9%	1.4%		59.3%
A&E attendances (0-4)	2011/12 - 13/14	337	471	530	22		2705
A&E attendances (5-17)	2011/12 - 13/14	196	301	307	5		1145
A&E attendances (<18)	2011/12 - 13/14	240	347	373	11		1504
Elective hospital admissions for all causes (<18)	2011/12 - 13/14	35.1	47.7	49.0	1.6		249.1
Emergency hospital admissions for all causes (<18)	2011/12 - 13/14	74.7	65.8	69.5	2.5		270.0
Emergency respiratory admissions (<18)	2009/10 - 13/14	4.9	3.8	3.8	0.4		14.5
Emergency gastroenteritis admissions (0-4)	2009/10 - 13/14	17.3	11.4	11.3	0.8		72.1
Emergency admissions for asthma, diabetes or epilepsy (<18)	2009/10 - 13/14	-	3.0	3.4	0.4		54.7
Admissions due to injury (<18)	2011/12 - 13/14	10.5	10.6	11.1	0.7		52.8
Outpatient first attendances (<18)	2011/12 - 13/14	368	282	246	6		1144
Ratio of first to follow-up outpatient attendances (<18)	2011/12 - 13/14	0.60	0.46	0.51	0.20		2.14
DNA rate for outpatient appointments (<18)	2011/12 - 13/14	12.3%	10.7%	11.5%	0.6%		32.3%

Chronic Kidney Disease

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
CKD: QOF prevalence (18+)	2014/15	7.6%	4.9%	4.1%	0.0%		23.8%
Exception rate for CKD indicators	2014/15	28.1%	9.5%	7.5%	0.0%		60.0%
CKD002: Last BP reading measured in last 12mths is <=140/85 (den. incl. exc.)	2014/15	53.2%	71.1%	74.4%	0.0%		100%
CKD003: Hypertension treated with ACE inhibitor/ARB (den. incl. exc.)	2014/15	75.0%	76.0%	76.4%	0.0%		100%
CKD004: Urine albumin:creatinine ratio test last 12 mths (den. incl. exc.)	2014/15	52.4%	75.8%	75.4%	0.0%		100%

Diabetes

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Diabetes: QOF prevalence (17+)	2014/15	8.6%	6.5%	6.4%	0.3%		20.4%
Exception rate for diabetes indicators (2014/15 indicators)	2014/15	4.4%	12.6%	10.8%	0.0%		49.0%
Hypertension: QOF prevalence (all ages)	2014/15	18.4%	15.2%	13.8%	0.1%		47.6%
Exception rate for hypertension indicator (2014/15)	2014/15	1.8%	5.0%	3.8%	0.0%		46.9%
Exception rate for smoking indicators (2014/15 indicators)	2014/15	1.1%	1.3%	1.0%	0.0%		65.0%
Obesity: QOF prevalence (16+)	2014/15	27.2%	10.1%	9.0%	0.0%		29.4%
DM007: Last HbA1c is <=59mmol/mol in last 12mths (den. incl. exc.)	2014/15	55.9%	60.3%	60.4%	0.0%		100%
DM008: Last HbA1c is <=64mmol/mol in last 12mths (den. incl. exc.)	2014/15	63.4%	68.7%	68.4%	0.0%		100%
DM009: Last HbA1c is <=75mmol/mol in last 12mths (den. incl. exc.)	2014/15	75.2%	80.4%	79.3%	0.0%		100%
DM002: Last BP is <=150/90 (den. incl. exc.)	2014/15	81.4%	85.4%	86.6%	0.0%		100%
DM003: Last BP is <=140/80 (den. incl. exc.)	2014/15	50.3%	67.2%	71.2%	0.0%		100%
DM004: Measured total cholesterol (last 12mths) <=5mmol/l(den.incl.exc.)	2014/15	76.6%	70.2%	70.8%	0.0%		100%
DM005: Record of micro-albuminuria test last 12mths (den. incl. exc.) - retired	2013/14	56.4%	76.7%	80.6%	1.1%		100%
DM006: Proteinuria/micro-album. treated w inhibitors (den. incl. exc.)	2014/15	100%	79.2%	81.2%	0.0%		100%
DM011: record of retinal screening (den.incl.exc.) - retired	2013/14	69.3%	77.4%	82.6%	0.0%		100%
DM012: Patients with diabetes who had a foot examination and risk classification (den.incl.exc.)	2014/15	73.1%	81.7%	81.5%	0.0%		100%
DM013: Patients with diabetes who had a dietary review (last 12mths) (den.incl.exc.) - retired	2013/14	37.1%	75.9%	82.2%	0.0%		100%
DM014: Newly diagnosed patients w. diabetes referred to education programme within 9 mths (den.incl.exc.)	2014/15	14.3%	49.6%	66.3%	0.0%		100%
DM015: Male patients w. diabetes asked about erectile disfunction (last 12 mths) (den.incl.exc.) - retired (Male)	2013/14	66.7%	69.8%	81.6%	0.0%		100%
DM016: Male patients w. diabetes w. erectile disfunction who got advice (den.incl.exc.) - retired (Male)	2013/14	70.8%	77.8%	87.9%	0.0%		100%
DM018: Flu vaccination coverage (den.incl.exc.)	2014/15	82.8%	76.4%	77.6%	37.0%		100%

Mental Health

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Mental Health: QOF prevalence (all ages)	2014/15	1.43%	0.85%	0.88%	0.06%		15.57%
Exception rate for MH indicators (2014/15 indicators)	2014/15	6.0%	11.8%	11.1%	0.0%		76.7%
Dementia: QOF prevalence (all ages)	2014/15	0.5%	0.9%	0.7%	0.0%		59.2%
% reporting Alzheimer's disease or dementia	2014/15	0.7%	0.9%	1.0%	0.3%		25.0%
Exception rate for dementia indicators	2014/15	0.0%	9.8%	8.3%	0.0%		100%
Depression: QOF incidence (18+) - new diagnosis	2014/15	3.3	1.3	1.2	0.0		18.2
Depression: QOF prevalence (18+)	2014/15	13.0%	8.1%	7.3%	0.0%		33.0%
Exception rate for depression indicator (2014/15 indicators)	2014/15	20.4%	25.5%	24.5%	0.0%		100%
% reporting a long-term mental health problem	2014/15	2.9%	4.8%	5.1%	0.4%		60.1%
MH002: comprehensive care plan (den. incl. exc.)	2014/15	54.5%	74.7%	77.2%	0.0%		100%
MH007: record of alcohol consumption for patients on the MH register (last 12 mnths), den. incl. exc.	2014/15	63.6%	77.1%	80.3%	0.0%		100%
MH006: record of BMI for patients on the MH register in preceding 12 months (den.incl.exc.) - retired	2013/14	70.8%	75.3%	78.8%	0.0%		100%
MH003: record of blood pressure check in preceding 12 months for patients on the MH register (den.incl.exc.)	2014/15	77.3%	79.7%	81.5%	0.0%		100%
MH008: Female patients (25-64 yrs) on the MH register who had cervical screening test in preceding 5 years (den. incl. exc.)	2014/15	44.4%	71.5%	71.6%	0.0%		100%
MH009: Patients on lithium therapy with record of serum creatinine and TSH in the preceding 9 months (den.incl.exc.)	2014/15	100%	93.9%	93.4%	0.0%		100%
MH010: Patients on lithium therapy with levels in therapeutic range in preceding 4 months (den.incl.exc.)	2014/15	100%	84.0%	82.6%	0.0%		100%
MH004: Patients on MH register with cholesterol check in preceding 12 months (den.incl.exc.) - retired	2013/14	45.5%	61.4%	68.0%	0.0%		100%
MH005: Patients on the MH register with blood glucose or HbA1c check in preceding 12 months (den.incl.exc.) - retired	2013/14	53.3%	71.0%	74.9%	0.0%		100%
DEP001: Newly diagnosed patients w. depression who had a bio-psychosocial assessment on diagnosis (current FY, aged 18+) (den.incl.exc.) - retired	2013/14	51.1%	68.3%	75.8%	0.0%		100%
DEP003: Newly diagnosed patients with depression who had a review 10-56 days after diagnosis (den.incl.exc.)	2014/15	38.9%	63.4%	63.8%	0.0%		100%
DEM002: Dementia care has been reviewed last 12mths (den.incl.exc.)	2014/15	80.0%	77.9%	77.0%	0.0%		100%
DEM003: Blood tests recorded (den.incl.exc.)	2014/15	100%	73.1%	74.7%	0.0%		100%

Musculoskeletal Conditions

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Osteoporosis: QOF prevalence (50+)	2014/15	0.6	0.2	0.2	0.0		9.6
Exception rate for OST indicators	2014/15	40.0%	13.0%	12.5%	0.0%		100%
Rheumatoid Arthritis: QOF prevalence (16+)	2014/15	1.05	0.82	0.73	0.00		4.60
Exception rate for RA indicators (2014/15 indicators)	2014/15	5.6%	8.4%	7.4%	0.0%		82.8%
% reporting a long-term back problem	2014/15	10.7%	9.6%	9.9%	0.0%		38.4%
% reporting arthritis or long-term joint problem	2014/15	14.7%	13.4%	12.8%	0.4%		34.9%
OST002: currently treated with a bone-sparing agent (50-74 yrs)(den.incl.exc.)	2014/15	66.7%	82.7%	82.8%	0.0%		100%
OST005: Patients (75+ yrs) with a fragility fracture treated with bone-sparing agent (den.incl.exc.)	2014/15	50.0%	78.4%	79.3%	0.0%		100%
RA002: Patients with rheumatoid arthritis who had a face-to-face review (last 12 mnths) (den.incl.exc.)	2014/15	72.2%	84.7%	84.3%	0.0%		100%
RA003: Patients w. rheumatoid arthritis, aged 30-84, who had an RA adjusted CV risk assessment (last 12 mnths) (den.incl.exc.) - retired	2013/14	93.8%	75.0%	86.8%	0.0%		100%
RA004: Patients w. rheumatoid arthritis, aged 50-90, who had an RA adjusted fracture risk assessment (last 24 mnths) (den.incl.exc.) - retired	2013/14	100%	68.5%	82.1%	0.0%		100%

Respiratory Disease

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
COPD: QOF prevalence (all ages)	2014/15	3.6%	2.0%	1.8%	0.0%		9.0%
Exception rate for COPD indicators	2014/15	10.7%	12.6%	12.3%	0.0%		57.8%
Asthma: QOF prevalence (all ages)	2014/15	6.9%	6.7%	6.0%	0.7%		12.5%
Exception rate for asthma indicators	2014/15	2.2%	9.4%	6.8%	0.0%		63.7%
Estimated smoking prevalence (QOF)	2014/15	27.4	17.3	18.4	0.0		83.3
Exception rate for smoking indicators (2014/15 indicators)	2014/15	1.1%	1.3%	1.0%	0.0%		65.0%
GP patient survey: smoking prevalence	2014/15	18.7%	15.6%	16.4%	1.3%		85.8%
GP patient survey: ex-smoking prevalence	2014/15	33.6%	30.6%	27.4%	0.5%		51.3%
COPD007: Influenza immunisation given 1 Aug - 31 Mar (den. incl. exc.)	2014/15	86.8%	80.8%	81.5%	0.0%		100%
COPD004: Record of FEV1 in last 12mths (den. incl. exc.)	2014/15	61.8%	75.8%	73.2%	0.0%		100%
COPD003: assessed using MRC dyspnoea score last 12mths (den. incl. exc.)	2014/15	65.8%	79.5%	79.9%	0.0%		100%
COPD002: Diagnosis conf. by spirometry (den. incl. exc.)	2014/15	50.0%	79.5%	81.1%	0.0%		100%
AST002: with measures of variability/reversibility (8+), den. incl. exc.	2014/15	82.4%	83.6%	84.3%	0.0%		100%
AST003: review in the last 12 months (incl. an assessment using the 3 RCP questions), den. incl. exc.	2014/15	60.7%	67.8%	69.7%	0.0%		100%
AST004: smoking recorded in last 12 mths (14-19y w asthma), den. incl. exc.	2014/15	83.3%	81.2%	83.9%	0.0%		100%
SMOK002: status recorded in last 12 mths (certain conditions), den.incl.exc.	2014/15	93.2%	93.5%	93.2%	0.0%		100%
SMOK005: cessation support and treatment offered (certain conditions), den. incl. exc.	2014/15	85.1%	93.3%	94.1%	12.6%		100%
SMOK001: record of smoking status in last 24 months (15+ y), den. incl. exc. - retired	2013/14	85.9%	83.2%	85.6%	2.1%		100%
SMOK004: record of offer of support and treatment (15+, last 24 mnths), den. incl. exc.	2014/15	77.0%	84.9%	85.8%	0.0%		100%
COPD005: Patients w. MRC dyspnoea score >=3 w.oxygen saturation value (last 12mths) (den.incl.exc.)	2014/15	92.9%	94.6%	94.5%	0.0%		100%

AMR Local indicators

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Total number of prescribed antibiotic items per 1000 registered patients by quarter	2016 Q1	229.6	161.1	160.2	0.1		2119.7
Total number of prescribed antibiotic items per STAR-PU by quarter	2016 Q1	0.42	0.27	0.30	0.00		4.06
Percentage of broad spectrum prescribed antibiotic items (cephalosporin, quinolone and co-amoxiclav class) by quarter	2016 Q1	13.06%	10.96%	9.87%	0.00%		100.00%

Other Conditions

Indicator	Period	Prac. Value	CCG Value	Eng. Ave.	Eng. Low.	England Range	Eng. High.
Epilepsy: QOF prevalence (18+)	2014/15	0.8%	0.9%	0.8%	0.1%		5.6%
EP002: Seizure free for last 12mths (den.incl.exc.) - retired	2013/14	25.0%	56.1%	61.2%	0.0%		100%
EP003: Contraception, conception and pregnancy (den.incl.exc.) - retired (Female)	2013/14	80.0%	39.6%	56.9%	0.0%		100%
Learning disability: QOF prevalence	2014/15	1.0%	0.5%	0.4%	0.0%		4.3%
LD002: Down's Syndrome with blood TSH record (den.incl.exc.) - retired	2013/14	100%	48.2%	54.7%	0.0%		100%
% reporting learning difficulty	2014/15	-	2.9%	2.6%	0.3%		30.8%
Hypothyroidism: QOF prevalence (all ages) - retired	2013/14	3.5%	3.8%	3.3%	0.0%		10.8%
THY002: function test recorded last 12mths (den.incl.exc.) - retired	2013/14	79.5%	92.9%	93.6%	0.0%		100%
Palliative/supportive care: QOF prevalence (all ages)	2014/15	0.1%	0.3%	0.3%	0.0%		35.3%
% reporting blindness or severe visual impairment	2014/15	-	1.4%	1.4%	0.3%		17.2%
% reporting deafness or severe hearing impairment	2014/15	3.5%	4.9%	4.0%	0.2%		17.2%

Healthwatch Plymouth

Knowledgeable today,
Powerful tomorrow.

Healthwatch Plymouth Report

Future GP Commissioning - Patient Impact

September 2016

Healthwatch is the consumer champion for health and social care in England. We give children, young people and adults a powerful voice to influence and challenge how services are provided in the city by making sure their views and experiences are heard by those who run, plan and regulate local health and social care services.

In 2012 the Health and Social Care Act set out that each local authority should establish a local Healthwatch. In 2013, Plymouth City Council undertook a competitive tender process and awarded the contract to an established local organisation called Colebrook (SW) Ltd.

Experienced in public and patient involvement, Colebrook launched Healthwatch Plymouth in April 2013, ensuring independence through its governance structures and a memorandum of understanding between those working in and delivering the services, and the organisation itself.

The following report considers the impact to patients registered at Hyde Park, St Barnabas and Cumberland GP Surgeries if services are not re-commissioned post March 2017. It includes a socio-demographic profile for each surgery as well as feedback from patients that have contacted Healthwatch Plymouth directly.

Background

Healthwatch Plymouth were approached by NHS England South (South West) lead for Communications and Engagement in early June 2016 to discuss a possible engagement process around future commissioning intentions for 6 existing GP Surgeries (Mount Gould, Ernesettle, Trelawny, Hyde Park, St Barnabas and Cumberland) in Plymouth as well as an additional new GP service being considered for the Barne Barton area of the city.

Healthwatch Plymouth advised on ways to engage with patients meaningfully and in a timely way. We discussed that patients should be given the opportunity to ask questions about the commissioning process, as well as have their experiences and concerns listened to. We advised that the communication plan should include a media release and individual patient letters for the surgeries involved. We were also happy to help facilitate any engagement where possible, but were clear that we would not lead the engagement activity (due to staff capacity), which was to be organised and run by NHS England.

Following notification from NHS England that there would be delays in posting the letters to patients, we made NHS England aware that we would be conducting an independent social media campaign to allow patients of Hyde Park, St Barnabas and Cumberland surgeries a voice about the future of GP services at these locations. This report utilises comments provided by patients and patient groups in its conclusions and recommendations. These comments are available in the attached Appendices.

Engagement

Full detail and comment on the engagement process as well as recommendations can be found in the attached Appendices. The following is a summary of the issues arising.

Delays in issuing patient letters as well as a media release made public prior to patients being informed, led to a hectic and disjointed first set of engagement events at Hyde

Park, St Barnabas and Cumberland surgeries. In some cases patient letters were received on the day of these first events leaving little chance for patients to make arrangements to attend. The timing of the first engagement event is also questionable falling towards the end of August (summer holiday period) and two days before the bank holiday weekend; times that traditionally we would expect to see a lower level of engagement from the public. A member of the Healthwatch Engagement Team was in attendance at the first event and helped with the completion of the engagement form. Experiences gathered at these events have been retained by NHS England.

As a result of the delayed patient letters, additional engagement events were planned by NHS England at all surgeries and a Healthwatch representative was in attendance at all events (with the exception of St Barnabas on 30 August). However, the timing of the second round of engagement straight after the bank holiday weekend is also concerning especially as communication of these additional dates to patients was only made available via a notice in the affected surgery's waiting room; no additional communication with patients via letter was made.

Healthwatch Plymouth had encouraged NHS England to facilitate Question and Answer sessions at surgeries, to provide open and honest information to those concerned. We suggested a panel discussion with members of the commissioning team, but were advised on two occasions that NHS England were hoping to avoid such sessions as staff found them uncomfortable, and they were concerned that they would not be able to provide enough information at this stage to sufficiently answer questions.

In addition, the sessions advertised as 90 minute sessions on the attached poster, were not possible on all dates, as some sessions had been planned over the lunchtime period when surgeries were closed.

Demographics

Each of the three surgeries are located in inner city neighbourhoods (Devonport, Stoke and Mutley), each with its own unique characteristics. The following is a socio-demographic summary for each area and further detail can be found in the appendices.

Devonport

Devonport is the most deprived neighbourhood in Plymouth[1] and is served by only 2 GP Surgeries within its boundaries, namely The Cumberland Surgery and Devonport Health Centre (who are collocated) with only 1 other Surgery in a 1 mile radius in Stonehouse. The Devonport Neighbourhood has the lowest life expectancy in the city with a high rate of emergency hospital admissions and dementia clients compared to the city-wide average. Compared to other neighbourhoods, Devonport also has a high rate of people claiming benefits and/or in receipt of care.[2] A sustained period of regeneration within the area is coming to a conclusion with an increase in housing, both private and council/housing association. The area also has services supporting the homeless, ex-offenders and those with alcohol and drug addiction run predominately by the third sector.

Stoke

[1] Plymouth City Council's Index of Multiple Deprivation 2015

[2] Plymouth City Council's Plymouth Report 2014 and Area Profile: Devonport Neighbourhood July 2014

Stoke is ranked as the 15th most deprived neighbourhood in Plymouth[3] (out of 39) and is also only served by two GP Surgeries within its boundaries, namely St Barnabas and Stoke who are situated 0.9 miles apart. Other surgeries within a 1 mile radius of St Barnabas are located to the south and east of the surgery. Life expectancy within Stoke is also low when compared to the city-wide average. Rates of emergency hospital admissions and the number of dementia clients are both high with dementia rates being higher than Devonport. The rate of persons with a learning disability is also above the city-wide average as are those claiming benefits and/or in receipt of care.[4] The area has several residential care and nursing homes as well as homes that specialise in adults with learning difficulties or adults who require assisted living. The main City College campus is also located in this area.

Mutley

Mutley is ranked as the 17th most deprived neighbourhood in Plymouth[5] and is served by two GP Surgeries at Hyde Park and Lisson Grove (0.5 miles apart). A further 4 surgeries are located within a 1 mile radius of Hyde Park, although not all are on public transport routes. Life expectancy is better than both Devonport and Stoke areas, but is still below the city-wide average. Rates of emergency hospital admissions and the number of dementia clients are both high. The number of benefits claimants are below the city-wide average, but those in receipt of care are above.[6] The area has a significantly higher population of 20-29 year olds attributed to the expansion of Plymouth University. Significant additional purpose built student accommodation is also being provide in Mutley (due to open Sept 2017).

Future Planning

In its vision for the city onwards to 2031 (Plymouth Plan 2015), Plymouth City Council has an aspiration to grow the population of the city in excess of 300,000 people (an increase of approx 40,000 on the 2015 population figure). In order to achieve this, substantial house building and regeneration will be required and the plan quotes approximately 7,900 additional houses for Southern Plymouth, which all three neighbourhoods fall into.[7]

Patient Impact

Healthwatch Plymouth has received 55 pieces of feedback at the time of this report about the potential for closure of Hyde Park, St Barnabas and Cumberland Surgery from patients. We have also received feedback from managers and residents at the following services:

- George House – homeless hostel
- Devonport Lifehouse – homeless centre
- Shekinah Mission – charity for individuals who are homeless, drug and alcohol in recovery

[3] Plymouth City Council's Index of Multiple Deprivation 2015
[4] Plymouth City Council's Plymouth Report 2014 and Area Profile: Stoke Neighbourhood July 2014
[5] Plymouth City Council's Index of Multiple Deprivation 2015
[6] Plymouth City Council's Plymouth Report 2014 and Area Profile: Mutley Neighbourhood July 2014
[7] Plymouth City Council's Plymouth Plan 2015 – Part One

- Charlton House Residential Care Home
- Chatsworth House Residential Care Home
- Norfolk Villa Residential Care Home
- Underhill House Residential Care Home
- Parkwood House Nursing Home (All patients have now re-registered with another practice due to services received from St Barnabas post 1 April 16)
- Two Trees Care Home – Adult Learning Disability (All patients have now re-registered with another practice due to services received from St Barnabas post 1 April 16)
- St Barnabas Court - Assisted living complex (Remain served by St Barnabas, due to location of surgery)
- Townsend House – housing support for ex-offenders

From the feedback received from patients and managers of the various services, centres and homes supported by the three surgeries, the view is that they are extremely valued and are predominately considered as delivering a good service.

Each of the three surgeries supports various vulnerable patient groups and concerns have been raised about access to services moving forward if surgeries are not re-commissioned. The groups include:

- Ex-offenders at Townsend House (Hyde Park)
- Homeless at Devonport Lifehouse, George House and Shekinah Mission (Cumberland Surgery)
- Alcohol & Drug rehabilitation at Hamoaze House and The Harbour Centre (Cumberland Surgery)
- Adult Learning Disability at Two Trees Care Home (St Barnabas)
- Adult Assisted Living at St Barnabas Court (St Barnabas)

In addition, an outreach programme for the homeless is commissioned by NEW Devon CCG and whilst running out of Ernesettle Surgery, utilises the services at the Cumberland Surgery to support this programme.

Further to this, there will be impact to both training placements and research projects run by the Peninsula Schools of Medicine and Dentistry delivered through partnership with Cumberland and Hyde Park Surgeries. The impact of this will be especially felt by the partnership with Cumberland Surgery that is not only delivering training placements, but is also involved in a longer term research programme in the Devonport neighbourhood as a direct response to national policy directives.

Patient Choice will also be affected by any closures as each surgery is one of only two in their prospective neighbourhood. Although there are other practices within a 1 mile radius of each affected surgery, the alternatives are not all served by public transport.

It is also clear that future population expansion, both imminent student and future projected population growth do not appear to have been considered fully in the proposals. The detail provided in NHS England's own Equality Impact Assessment Form –

Devonport has been called into question by a report of petition responses and stakeholder perspectives produced by the Friends of Cumberland Centre PPG.[8]

The impact of the proposed closure of these surgeries appears to be being taken in isolation and may not have considered the impact of recent closures at Sutherland Road (Mutley) or Glendower Surgery (Peverell/Mutley). Equally we understand that a further surgery is soon to close on the border of north Devonport due to the handing back of the GP contract.

Conclusions

Despite being contacted by NHS England to discuss ways to engage patient groups, we do not feel that the engagement plan for Cumberland, Hyde Park and St Barnabas was well considered. Information provided to Healthwatch and patients had inconsistencies and was potentially misleading. Delays in delivery of patient letters coupled with engagement events either side of a bank holiday has led to anger from patients about the process, many patients voicing that it was 'paying lip service to engagement' or that 'a decision to not recommission services has already been made'.

Data used has not been consistent during the process, data provided to Healthwatch at the beginning of the process shows list size information from 2014, but is quoted as being from 2016. This has the potential to be considered misleading.

Healthwatch Plymouth has substantial concerns that health inequalities will increase and reduced access to GP services will be witnessed, especially from extremely vulnerable groups particularly if the Cumberland Surgery were to close. In turn, there is a risk that this may ultimately lead to additional pressures on Accident and Emergency services or other crisis based provision.

Equally with the recent closure of Sutherland Road and Glendower surgeries in 2015, plus the imminent rise in the student population, Healthwatch Plymouth is concerned that there is potential for insufficient GP capacity in the Mutley Neighbourhood to support this patient increase; as well as providing health care access to services that support vulnerable adults.

We are not confident at this stage that the Equality Impact Assessment carried out has addressed this sufficiently.

Recommendations

1. Further engagement activity with patients and agencies is conducted to fully inform the Equality Impact Assessment for each Surgery.
2. Future engagement activity needs to be robust. Consider issues that could significantly pose challenges in its delivery. Challenges include delay in letters, notification of additional engagement opportunities and patient expectations of engagement.
3. Patient letters should contain the most up to date information to avoid being considered as misleading.

[8] Cumberland Surgery Closure – NHS Equality Analysis Critique. A report of petition responses and stakeholder perspectives produced by the Friends of Cumberland Surgery PPG with independent advice by Dr Sam Regan de Bere (BSc Hons, PGDip, MSc, PhD) and Rebecca Baines (BSc Hons, MSc).

4. Letters should be clear as to what the purpose of the engagement is for so that members of the public have an unambiguous understanding of the event.
5. Equality impact statements must use multiple sources and the most accurate available data to ensure they cannot be construed as biased or misleading.

K Marcellino
Manager
Healthwatch Plymouth

Appendix 1 – Socio-Demographic Profiles for Devonport, Mutley & Stoke and Practice Information for Cumberland, Hyde Park and St Barnabas Surgeries

Appendix 2 – Cumberland Surgery Closure – NHS Equality Analysis Critique. A report of petition responses and stakeholder perspectives produced by the Friends of Cumberland Surgery PPG

Appendix 3 – Comments from Services associated with Cumberland, Hyde Park and St Barnabas Surgeries

Appendix 4 – Comments From Patients and Patient Groups

Appendix 5 – Engagement Process

Distribution:

Julia Cory, Head of NHS England South (Southwest) Primary Care Commissioning

Copy to:

Primary Care Commissioning, Western Locality NEW Devon CCG

Chair, Plymouth City Council Health & Wellbeing Board

Director of Public Health at Plymouth City Council

Chair, Plymouth City Council Wellbeing Overview & Scrutiny Committee

Ward Councillors for Devonport, Peverell and Stoke

Appendix 1

Socio-Demographic Profiles for Devonport, Mutley & Stoke and Practice Information for Cumberland, Hyde Park and St Barnabas Surgeries

SOCIO-DEMOGRAPHIC PROFILE FOR THE NEIGHBOURHOOD OF DEVONPORT & CUMBERLAND SURGERY

The Cumberland Surgery is located at the South-Eastern end of Devonport neighbourhood and sits close to the Plymouth City Council (PCC) neighbourhood boundary of Stonehouse and Stoke. It is also adjacent to two further inner city neighbourhoods. The Devonport neighbourhood is currently served by two GP Surgeries, namely The Cumberland Surgery and Devonport Health Centre both located in Damerel Close. Further surgeries within a 1 mile radius are:

- Adelaide Street Surgery (0.9 miles)

Also, one other surgery within a 1 mile radius has relocated in the past 16 months namely:

- Marlborough Street Surgery (0.8 miles) – closed July 2015, practice relocated to Cumberland Centre campus as Devonport Health Centre

Public Transport Links: The Cumberland Surgery is located adjacent to several bus routes run by both City Bus and Stagecoach South West that run through the Devonport neighbourhood. Bus stops are available close to the Surgery on Cumberland Road.

The population footprint for Devonport in 2013 was 6344. The overall Index of Multiple Deprivation 2015 score ranks Devonport as the most deprived neighbourhood in Plymouth out of 39. In 2013, 23.4% of the population were claiming some sort of benefit (above the city-wide figure of 11%) with 10.9% of the working population claiming jobseekers allowance (city-wide figure is 3.7%). When comparing age groups with the overall Plymouth population, it generally mirrors that of the city with no significant differences except for males in the 20-24 age group, which is lower than the city average. Devonport and the adjacent neighbourhoods have all seen an increase in GP population registration over the period 2001 to 2013 (Source: Plymouth City Council's Plymouth Report 2014 and Index of Multiple Deprivation 2015)

Average life expectancy for the Devonport Neighbourhood area in 2010-12 was 73.6 years (below the city-wide figure at 80.5 years). The rate of emergency hospital admissions in 2012/13 was 1,232.5 per 10,000 population (above the city-wide figure of 875.2). Also in 2012/13, the rate of all clients in receipt of care was 460.5 per 10,000 population aged 18+ (above the city-wide figure of 354.5) and the rate of dementia clients was 58.9 per 10,000 population aged 18+ (again above the city-wide figure of 43.0). (Source: PCC's Area Profile: Devonport Neighbourhood July 2014)

Population planning.

In its vision for the city onwards to 2031 (Plymouth Plan 2015), Plymouth City Council has an aspiration to grow the population of the city in excess of 300,000 people (an increase of approx 40,000 on the 2015 population figure). In order to achieve this, substantial house building and regeneration will be required and the plan quotes approximately 7,900 additional houses for Southern Plymouth.

Devonport Neighbourhood has seen a sustained period of regeneration over the past few years that has resulted in redevelopment of areas of the South Yard of HM Naval Base, the area around Devonport Guildhall and the ex MOD site at Mount Wise in providing new build housing as well as regeneration of existing buildings. The area around Millbay Docks is also undergoing a major redevelopment resulting in additional housing. A key challenge of the plan is '*to improve health and wellbeing in the city overall and particularly to reduce health inequalities*' by establishing Healthy Communities that '*will be a place where an ageing population can live independently, reducing the need for residential care or hospitalisation*'. The plan also acknowledges a reduction in public sector spending and increasing pressure on care services to meet the needs of an ageing population (Source: PCC's Plymouth Plan 2015 – Part One)

Appendix 1

PRACTICE INFORMATION

Unlike Hyde Park and St Barnabas, the Cumberland Surgery was not commissioned by NHS England, but was set up by Plymouth Community Healthcare (now Livewell SW) in 2013. The aim was to provide high quality clinical care, combined with teaching and research in the area with the highest need in the city. The surgery was established as a partner practice with Ernesettle, Mount Gould and Trelawny – all previously run by Livewell and now run by Access Health Care under an interim contract. The practice currently has approximately 2000 registered patients.

The current location of the GP Surgery within the Cumberland Centre is not ideal due to ergonomics of the building. However, public money from the Devonport Regeneration Fund to the sum of £1.4M was allocated to the centre for refurbishment purposes to support a key objective of the Devonport Regeneration Plan '*to improve the health of the Devonport community'*. (Source: PCC's Devonport Area Action Plan – Adopted Version Chapter 7)

The Cumberland Surgery delivers the following services as part of its contract as well as GP access:

- Ante-Natal services with a weekly midwife clinic (these are held at Green Arc Children's Centre)
- Practice Nurse
- Phlebotomist
- Clinics in support of long term conditions (diabetes, heart disease, High Blood Pressure, COPD
- Minor Surgical Procedures
- Non-complex dressings (access to more complex dressing requirements is through other Access Health Care run surgeries)
- Asthma Clinic
- Learning Disability Health Check

It also provides GP Services for the following patient groups

- Devonport Lifehouse – homeless centre run by the Salvation Army
- George House – Homeless accommodation run by BCHA
- Shekinah Mission – charity providing opportunities for people in recovery including homelessness, drugs and alcohol issues, offending behaviours or mental health
- The Harbour Centre - assists recovery for people experiencing harm caused by substance misuse. The practice has specialist doctors who work with Harbour in instituting and monitoring Opiate Substitution treatment and providing Alcohol detox services
- Hamoaze House -Plymouth based day centre for drug and alcohol rehabilitation supporting people with multiple complex needs

In addition. Cumberland Surgery provides training places for medical students from the Peninsula Medical and Dental School and also provides placements for other Plymouth University healthcare students including Nursing and Clinical Psychology. The practice also arranges voluntary placements for medical and other healthcare students to Devonport organisations such as Devonport House. (Source: Cumberland Centre Surgery & NHS Choices)

PATIENT VIEW

The surgery is highly thought of by its patients and services it supports and has an active Friends of Cumberland Surgery PPG who have run an active online petition against closure that has had 735 signatories (as of 22 Sept 16).

The practice is seen as being very well managed and supportive to patients '*It's not just the practice nurse or the doctor it's the whole thing the atmosphere is lovely when you go down*

there.' patients also have trust in the medical staff. It is also seen as serving a disadvantaged community by its support to *'…patients include(ing) many residents of homeless hostels and other vulnerable people…*'. As with the other surgeries, patients are particularly angry with the way that the engagement process has occurred '*…I feel this process has been severely mismanaged…*' and '*It was apparent from the tenor of the conversation my wife and I had with the NHS England representative that NHS England have already made up their minds that Cumberland Surgery will close. They only attend such drop-in sessions to give the impression that a proper consultation process is taking place.*'

There have also been several comments from both staff and individuals from services supported by the Cumberland Surgery as to how that proactive support is changing their lives. It is best summed up by the following from a volunteer who works with Shekinah, Devonport Lifehouse and the Plymouth City soup run:

All of these services are accessed by patients with complex needs, many of them homeless or vulnerably housed, and many of them registered with the Cumberland Surgery and its group practice partners.

The majority of these patients, through various day-to-day challenges, historical events and difficulties coping with life are not always able to give a high priority to their health. Access to a caring and creative GP service that is well-networked with other services in the community is invaluable for such patients. And a GP service that 'goes the extra mile' for patients for whom engagement is itself a challenge will, as well as delivering health and wellbeing gains to individual patients, lead to savings to the public purse.

Recourse to paramedic services and hospitalisation is not uncommon for patients with complex needs, who can leave conditions to develop to a critical stage rather than seeking timely attention. Strategies that encourage patients to be more engaged and proactive in their health will counter this trend. The Cumberland Surgery provides a welcoming, non-judgemental environment for patients. It has excellent connections with local community services and the Medical School, through which it creates opportunities for patients to meet practitioners in training for mutual benefit. Patients become familiar and comfortable talking to professionals and students hone their skills in communicating with vulnerable patients making them better doctors for when they practise as GPs or in other specialisations.

Some examples of how the Cumberland Surgery has supported such patients:

'A' is a formerly homeless man who has been dependent on alcohol for about 15 years. He has significant damage to his liver. He is a shy person, with very low self-confidence, problems with his teeth that impede social interactions and a painful ankle injury affecting mobility. 'A' became very withdrawn and depressed, feeding further into a lack of motivation to address his problems. However, over the last two years or so, he has had good contact with his GP and has articulated his concerns and wishes to recover. His GP has gently and persuasively drawn 'A' into a strategy for recovery involving support from Harbour Drug and Alcohol Services, Hamoaze House day recovery centre, Social Services, soup run and Salvation Army volunteers, and the Dental School. These services worked together to support 'A' and he is now in rehab, 3 months alcohol free and addressing his wider medical and dental issues. The GP was central to this support package and maintained momentum when the patient's motivation was slipping and when other services would have let him go.

'B' is a formerly homeless man living in a recovery house. He 'dropped off the radar' when moving between accommodations, coinciding with a worrying hospital test result which his GP considered warranted urgent attention. Initial efforts to trace 'B' at his last known address failed as did calls to other local homelessness services. So the GP contacted the writer who, through soup run and Shekinah connections was able to trace 'B' at his new address, and make an appointment for him to facilitate urgent follow-up treatment.

Many other examples could be cited involving vulnerable patients who have self-harmed, who have long-standing mental health conditions, or who have learning disabilities or lasting effects of historic abuse or trauma including from military service. These cases are not easily treated

with 10 minute appointments and dispensing of pharmaceutical solutions. They need treating with respect, listening to, asking what resources they can draw on and what they want to help them get better, encouragement to stick with treatments, and the message that they are worthy of help. This ethos practised and promulgated by the Cumberland Surgery makes creative use of resources available in the community, and seeks sustainable solutions for patients to point them towards healthy and purposeful lives.

The surgery also provides training support to the Peninsula Schools of Medicine and Dentistry. The Dean has commented '*We have developed a clear vision of the Cumberland location within Devonport as a centre for contemporary primary care in dentistry (through the dental school) and medicine (through the Cumberland practice) and have made tremendous progress in delivering this ambition. In particular the integration of service provision, undergraduate teaching in medicine, nursing and other allied health professions and research is without doubt the correct model.*

Closure of the general practice will destroy the learning experience, markedly setback the ability of our medical school to deliver new GPs for the future, greatly setback the research projects which are delivered through the practice and send a most unfortunate signal to the community.'

The Academic Lead for Medical Humanities at Peninsula Schools also expressed '*…we are strengthening patient empowerment through co-production with multi-professional staff and students. This work, which forms part of a larger ethnographic study of developments in Devonport, is a direct response to national policy directives. It has already generated an evidence base for PPGs (and) helped to inform policy at NHSE …*'

HEALTHWATCH COMMENT

As with the other practices affected by potential non-recommissioning, the Cumberland Surgery is held in high regard by its patients and is continuing to thrive and grow. It is one of only two GP Surgeries located in the most deprived neighbourhood in Plymouth; a neighbourhood that has many health and wellbeing challenges.

Since its introduction in 2013, staff at the Surgery have recognised their unique location and have actively worked with other agencies, support services and medical teaching schools in working with vulnerable groups as well as looking after their regular patient population. Being collocated with other Livewell services, PHNT community clinics and the Dental Facility provided by the Peninsula School of Dentistry, has allowed them to provide a more holistic approach to support and care for those that may not ordinarily access services. Therefore this surgery along with other services located on the Cumberland Centre campus is ideally placed to become a hub for community health and wellbeing as envisaged by the Plymouth Plan and the NEW Devon's Transforming Community Services.

Additionally, Friends of Cumberland Surgery PPG, with independent advice by Dr Sam Regan de Bere (BSc Hons, PGDip, MSc, PhD) and Rebecca Baines (BSc Hons, MSc) have conducted an equality analysis critique on NHS England's Equality Impact Assessment Form – Devonport that was sent to the Chair of the Cumberland PPG. The critique questions some of the assumptions and outcomes from NHS England's own Equality Impact Assessment Form for Devonport. Patients of the Cumberland Surgery have been actively engaged in their report, especially those that have complex needs due to homelessness, alcohol and/or drug addiction. The Executive Summary of the report of the Friends of Cumberland Surgery PPG is at Appendix 2.

Support to the homeless and those suffering alcohol and/or drug addiction.

The work undertaken by both this surgery and the NEW Devon CCG contracted Outreach programme with these vulnerable groups has generated real results as evidenced by the statement above. Healthwatch Plymouth has also engaged with individuals from George House and Hamoaze House about their experiences, but more importantly the challenges that individuals would face if the Cumberland Surgery was to close. It was clear from these discussions that trust had been established between them as patients and the surgery staff with

the outcome being that they were more likely to see a health professional because of this. It was also clear that those individuals who had accessed other GP services in the area, did not share this view and considered that they were not being treated in an engaged or inclusive manner. Those being seen at the Cumberland Surgery when asked about their concerns about finding another GP either felt confident in doing so or expressed real concerns about having to build new relationships and therefore would possibly not re-engage with another GP practice. The Cumberland Surgery currently provides Opiate Substitution treatments for around 90 patients; a number that is growing.

The role that the Surgery has in providing placements for trainees should not be underestimated, especially given the exposure to vulnerable and complex patients at an early stage of their career is viewed as extremely beneficial. Also current long term research projects in the Devonport area run in conjunction with the Peninsula Schools of Medicine and Dentistry are highly likely to be impacted by non-recommissioning of the Cumberland Surgery.

Healthwatch Plymouth has substantial concerns that health inequalities could potentially increase and reduced access to GP services will be witnessed from an extremely vulnerable group. In turn, there is a risk that this may ultimately lead to additional pressures on Accident and Emergency services or other crisis based provision.

We are not confident at this stage that the Equality Impact Assessment addresses this sufficiently, and make formal recommendation that further engagement with patients and agencies takes place to evidence this.

Appendix 1

SOCIO-DEMOGRAPHIC PROFILE FOR THE NEIGHBOURHOOD OF MUTLEY & HYDE PARK SURGERY

Hyde Park Surgery is located at the North end of Mutley Plain and sits on the Plymouth City Council (PCC) neighbourhood boundary of Peverell & Hartley and Mutley. It is also adjacent to three other inner city neighbourhoods. The Mutley neighbourhood is currently served by two GP Surgeries, namely Hyde Park and Lisson Grove. Further surgeries within a 1 mile radius are:

- Peverell Park Surgery (1 mile)
- Collings Park Surgery (0.7 miles)
- Mannamead Surgery (0.5 miles)
- Park View Surgery (0.4 miles)

Also, two other surgeries within a 1 mile radius have closed in the past 16 months namely:

- Sutherland Road Surgery (0.7 miles) – closed April/May 2015, GP now part of North Road West Surgery. Planning permission applied for and provisionally granted to convert old surgery premises into flats.
- Glendower Surgery (0.5 miles) – closed July 2015 on opening of Devonport Health Centre

Public Transport Links: Hyde Park Surgery is located adjacent to several bus routes run by both City Bus and Stagecoach South West that either pass through the north end of Mutley Plain heading towards Mannamead and Crownhill or traveling west/east along Hyde Park Road to/from Peverell. There is one stop adjacent to the surgery for services travelling east from Peverell.

The population footprint for Mutley in 2013 was 3732. The overall Index of Multiple Deprivation 2015 score ranks Mutley as the 17th most deprived neighbourhood in Plymouth out of 39 (Up from 22nd in 2010). In 2013, 9.8% of the population were claiming some sort of benefit (below the city-wide figure of 11%) with 4.0% of the working population claiming jobseekers allowance (city-wide figure is 3.7%). When comparing age groups with the overall Plymouth population, it generally mirrors that of the city with notable differences in the 20-24, 25-29 and 35-39 age groups for males and 20-24 for females, where numbers are higher. The higher numbers in the 20-24 age group is attributed to Plymouth University expansion over the last 10 years. With the exception of Higher Compton & Mannamead, Mutley and the adjacent neighbourhoods have seen an increase in GP population registration over the period 2001 to 2013 (Source: PCC's Plymouth Report 2014 and Index of Multiple Deprivation 2015)

Average life expectancy for the Mutley Neighbourhood area in 2010-12 was 78.7 years (below the city-wide figure at 80.5 years). The rate of emergency hospital admissions in 2012/13 was 1,016.7 per 10,000 population (above the city-wide figure of 875.2). Also in 2012/13, the rate of all clients in receipt of care was 406.3 per 10,000 population aged 18+ (above the city-wide figure of 354.5) and the rate of dementia clients was 111.7 per 10,000 population aged 18+ (again above the city-wide figure of 43.0). (Source: PCC's Area Profile: Mutley Neighbourhood July 2014)

Population planning. In its vision for the city onwards to 2031, Plymouth City Council has an aspiration to grow the population of the city in excess of 300,000 people (an increase of approx 40,000 on the 2015 population figure). In order to achieve this, substantial house building and regeneration will be required and the plan quotes approximately 7,900 additional houses for Southern Plymouth.

Mutley Neighbourhood is a mix of predominately Victorian residential housing and small retail premises. It is also a hub for student social activity. 51.2% of the private sector housing are deemed to be Non-decent homes (above the city-wide average of 33.3%). Situated to the North of the University campus, a major new development of student accommodation is underway on the old Royal Eye Infirmary site located on the boundary of Mutley and Greenbank & University neighbourhoods. (Source: PCC's Plymouth Plan 2015 – Part One and PCC's Area Profile: Mutley Neighbourhood July 2014)

Appendix 1

PRACTICE INFORMATION

The patient population for Hyde Park Surgery has seen sustained growth over the past three years with the number of new registrations since 1 April 2016 at 277 (as at 23 August 2016) Hyde Park Surgery delivers the following services as part of its contract as well as GP access:

- Ante-Natal services with a weekly midwife clinic (3 times the average pregnancy rate because of the demographic)
- Daily Practice Nurse clinic
- Phlebotomy service
- Full range of nurse appointments for those with chronic diseases
- Minor Surgical Procedures
- Non-complex dressings (access to more complex dressing requirements is through other Access Health run surgeries)
- Learning Disability Health Checks
- Monitoring of high risk drugs
- Weight Management
- Smoking Cessation
- ECG
- Spirometry
- Ear irrigation
- Travel advice and immunisation

It also provides GP Services for the following patient groups

- Townsend House – Local Authority Housing Support for ex-offenders
- Support to Residential/Nursing Homes – Chatsworth House & Charlton House
- Students at Plymouth University

In addition it also provides training places for medical students from the Peninsula Medical and Dental School and has, over many years, been highly credited for its placements. (Source: Hyde Park Surgery & NHS Choices)

PATIENT VIEW

Hyde Park Surgery is viewed as an extremely well managed practice that is '*exceptional in its delivery of healthcare services and caring for patients*' and '*The 6 Cs: Care, Compassion, Competence, Communication, Courage and Commitment which should be integral to the care of patients has always been clearly shown in this practice*'. There is a lot of anger amongst patients who see this as '*short sighted*' and nothing but '*a cost cutting exercise*' and actually question whether, in the long term, any actual savings would be made. They are particularly angry over the way the engagement process has occurred summed up by this comment '*I am appalled at the inadequate (less than 24hrs) notice initially given to patients by NHS England South West to attend the "consultation meeting" held at the surgery. I was unable to attend this meeting at such short notice...*'.

Supported services are equally concerned. The Care Manager at Chatsworth Residential Home commented '*Chatsworth Residential Home would be gutted to lose Hyde Park surgery because it is such a well-run surgery - they are efficient, attentive, polite, helpful…*'. She went on to say '*We know that when we contact this surgery they listen and offer a really personal service that our residents would not get anywhere else and I know this because we have odd residents at other surgeries, as it is their choice and the service from the other 5 surgeries does not even come close to Hyde Park.*'. Equally the Care Manager at Charlton House Residential Home commented '*Hyde Park have been a constant in the running of Charlton House - our longest serving surgery…*'. She further commented '*What makes Hyde Park so special is the same reason that it could potentially be closed for in that it is a small practice but critically has all the elements the larger practices are missing with a family feel and continuity of care with GPs and*

a team that go that extra mile to provide a standard of care that everyone deserves and is entitled to but sadly all too often these days do not receive.'.

Townsend House ex-offenders housing support, houses ex-offenders many with complex needs. Residents at the hostel commented on how they feel '*involved, engaged and valued*' with this surgery and how the staff have helped engender a feeling of trust with them as patients. One individual also commented '*I have finally found a place that my mental health needs are addressed correctly.*' A previous manager of Townsend House commented '*When I managed Townsend House I was always reassured that the medical needs of complex patients would be managed. Not only would they be managed but they would be made to feel a part of the community and valued. There are several ex residents that I still see today who maybe wouldn't have got so far if it wasn't for your surgery's care and support*'.

HEALTHWATCH COMMENT

It is clear from comments made by patients and services supporting vulnerable patient groups receiving care; that Hyde Park Surgery is highly valued and that this has been built up over a long period of time. The surgery has seen sustained growth over a number of years (Source: NHS Quarterly Data on GP Practise size for Devon Mar 13 – Jun 16) and continues to grow with a patient size approaching 2900. Indeed since April 2016 nearly 300 new patients have been registered. In particular, its Ante-Natal services are held in high regard and, because of the demographics, has on average 3 times the number of clients of other Ante-Natal clinics.

Although the surgery maybe considered to be small in scale based on number of patients registered, its recent change of interim provider to Access Health Care has brought benefits by reducing the need for a dedicated Practice Manager and by opening up access to additional services under a hub and spoke model – a model supported under the Sustainability Transformation Plan and GP forward view.

Whilst acknowledging the current climate that the NHS finds itself in with regards to funding and GP numbers (particularly in Plymouth and Devon) plus the case for change that has been put forward, it appears difficult to understand from a patient and public point of view why a successful surgery that caters for the needs not only of patients and vulnerable patient groups, but also supports the Peninsula Medical and Dental School by providing valuable training places for students, is being considered for non-recommissioning. It would also appear that little consideration has been given to the planned increase in population that the neighbourhood of Mutley will see, especially an increase in the student population with the building of accommodation right on the doorstep that is due for occupation from September 2017.

It is acknowledged that the GP Provider withdrew from this contract leading to the current interim measure. The reasons for this have not always been fully transparent when discussed in public forums leading to confusion for the patients of this surgery.

With the recent closure of Sutherland Road and Glendower surgeries in 2015, plus the imminent rise in the student population, Healthwatch Plymouth is concerned that potentially there may be insufficient GP capacity in the Mutley Neighbourhood to support this patient increase; as well as providing health care access to services that support vulnerable adults.

Appendix 1

SOCIO-DEMOGRAPHIC PROFILE FOR THE NEIGHBOURHOOD OF STOKE & ST BARNABAS SURGERY

St Barnabas Surgery is located in the Millbridge district of the Stoke neighbourhood and sits on the Plymouth City Council (PCC) neighbourhood boundary of Stoke and Stonehouse. It is also adjacent to three other inner city neighbourhoods. The Stoke neighbourhood is currently served by two GP Surgeries, namely St Barnabas and Stoke (0.9 miles from St Barnabas). Further surgeries within a 1 mile radius are:

- Armada Surgery (1.0 miles)
- Adelaide Street Surgery (0.9 miles)
- North Road West Medical Centre (0.9 miles)
- Park View Surgery (0.9 miles)

Also, one other surgery within a 1 mile radius has closed in the past 16 months namely:

- Sutherland Road Surgery (0.9 miles) – closed April/May 2015, GP now part of North Road West Surgery. Planning permission applied for and provisionally granted to convert old surgery premises into flats.

Public Transport Links: There are no bus stops adjacent to the surgery, but City Bus and Stagecoach South West services travel Stuart Road/Wilton Street, which are two streets north of St Barnabas Terrace. The nearest stop is on the corner of Wilton Street and Victoria Avenue approximately 200 meters from the surgery. There are only 2 regular services that run during Surgery opening hours.

The population footprint for Stoke in 2013 was 9242. The overall Index of Multiple Deprivation 2015 score ranks Stoke as the 15th most deprived neighbourhood in Plymouth out of 39 (Up from 16th in 2010). In 2013, 12.2% of the population were claiming some sort of benefit in 2013 (above the city-wide figure of 11%) with 5.5% of the working population claiming jobseekers allowance (city-wide figure is 3.7%). When comparing age groups with the overall Plymouth population, it generally mirrors that of the city with no significant differences. Stoke and the adjacent neighbourhoods have all seen an increase in GP population registration over the period 2001 to 2013 (Source: PCC's Plymouth Report 2014 and Index of Multiple Deprivation 2015)

Average life expectancy for the Stoke Neighbourhood area in 2010-12 was 76.2 years (below the city-wide figure at 80.5 years). The rate of emergency hospital admissions in 2012/13 was 863.5 per 10,000 population (above the city-wide figure of 875.2). Also in 2012/13, the rate of all clients in receipt of care was 588.3 per 10,000 population aged 18+ (above the city-wide figure of 354.5) and the rate of dementia clients was 133.0 per 10,000 population aged 18+ (again above the city-wide figure of 43.0). The rate of clients with a learning disability was 68.1 per 10,000 population (above the city-wide figure of 54.3). (Source: PCC's Area Profile: Stoke Neighbourhood July 2014)

Population planning. In its vision for the city out to 2031 (Plymouth Plan 2015), Plymouth City Council has an aspiration to grow the population of the city in excess of 300,000 people (an increase of approx 40,000 on the 2015 population figure). In order to achieve this, substantial house building and regeneration will be required and the plan quotes approximately 7,900 additional houses for Southern Plymouth.

Stoke Neighbourhood is predominately a residential housing area made up of various types of housing stock. Of these 44.7% of the private sector housing are deemed to be Non-decent homes (above the city-wide average of 33.3%). The City College Kings Road campus is also located within the area footprint. There are currently no major building developments within the Stoke area. (Source: PCC's Plymouth Plan 2015 – Part One and PCC's Area Profile: Stoke Neighbourhood July 2014)

Appendix 1

PRACTICE INFORMATION

The patient population for St Barnabas was 1605 on 30 June 16 and has reduced by nearly 100 patients since 1st April when Access Health Care took over as interim contract provider. St Barnabas Surgery delivers the following services as part of its contract as well as GP access:

- Phlebotomist
- Clinic in support of long term conditions
- Minor Surgical Procedures
- Non-complex dressings (access to more complex dressing requirements is through other Access Health Care run surgeries)
- NHS Health checks

It also provides GP Services for the following patient groups

- Support to Residential/Nursing Homes – Norfolk Villa and Underhill House Residential Homes
- Support to St Barnabas Court (Assisted living complex)

Until recently it also supported (see Healthwatch Comment below for details):

- Parkwood Nursing Home
- Two Trees Care Home (Adult Learning Disability)

(Source: St Barnabas Surgery & NHS Choices)

PATIENT VIEW

Despite being a single GP service, St Barnabas is generally held in high regard by its patients '*As a small practice they know you, and you know them. This makes for a trusting and pleasant healthcare experience.*' Patients have registered with them from larger practices because *'(My wife) had problems with a nearby large surgery, to the extent that dealing with them made her anxious and tearful and she avoided using them.*'

Services supported by the Surgery have commented positively on the relationship they had with the previous GP before his retirement.

HEALTHWATCH COMMENT

Although St Barnabas' location places it equidistance from 5 other GP Practices, the area is not overly well supported by public transport with only 2 services that run on a frequent basis. Both of these services travel to/from Stoke from/to the City Centre. These services do not travel near either Adelaide Street or Park View Surgeries. The likelihood is that patients at St Barnabas would choose to re-register at Stoke, Armada or North Road West surgeries if St Barnabas was not recommissioned.

St Barnabas Court assisted living complex for the elderly, was developed on adjoining redundant church land taking advantage of the ready proximity to medical care provided by St Barnabas Surgery (provided to 75% of the residents). Many of the elderly and infirm patients are able to make the short journey independently or with assistance to St Barnabas, but would find it physically impossible to journey further necessitating an increased demand for time consuming home visits.

Due to uncertainty in commissioning post March 2017 and also because of the perceived inefficiency of the service being delivered under the interim contract, residents of Parkwood House Nursing Home and Two Trees Care Home advised us that patients previously registered at St Barnabas have re-registered with other surgeries since 1 April 16. It is likely that a reasonable proportion of the reduced surgery patient numbers are attributable to this. Equally the retirement of a valued GP cannot be understated and will most certainly have had an effect.

Appendix 2

Cumberland Surgery Closure – NHS Equality Analysis Critique. A report of petition responses and stakeholder perspectives produced by the Friends of Cumberland Centre PPG with independent advice by Dr Sam Regan de Bere (BSc Hons, PGDip, MSc, PhD) and Rebecca Baines (BSc Hons, MSc)

The Friends of Cumberland Surgery PPG, with independent advice from Dr Sam Regan de Bere (BSc Hons, PGDip, MSc, PhD) and Rebecca Baines (BSc Hons, MSc), have conducted an equality analysis critique on NHS England's Equality Impact Assessment Form – Devonport, sent to the Chair of the Cumberland PPG.

The critique raises concerns over the information contained in the statement and concludes that the '*assessment is not based on rigorous primary research or empirical evidence and shows clear signs of bias*'. Healthwatch Plymouth have concerns that the NHS Equality Impact Assessment could be construed as having been produced to support a view; rather than providing information that provides conclusions from numerous facts around the demographics and patient population for this surgery. We have made recommendations regarding this document elsewhere in this report.

The following is the Executive Summary from that report.

Executive summary:

Negative impacts identified by existing patients/stakeholders:

- Elimination of patient choice
- Termination of "vital" GP service that is highly valued amongst the local, lay and professional communities
- Reduced accessibility
- Enhanced inequality
- Termination of established, therapeutic and trustful relationships
- Loss of high quality service tailored to the local community
- Disruption of existing hub of services available under one roof. Such a "one stop shop" all based at the Cumberland Centre having been the clear preference of extensive community consultation
- Extinction of unique community centred/ 'family-like' surgery ethos
- Absence of patient trust, confidence and belief in alternative GP surgery
- Enhanced anxiety accessing bigger surgeries, adjusting to new people and possibility of having to retell painful pasts
- Non-engagement/treatment adherence due to ineffective therapeutic relationships and/or accessibility issues
- Increased pressure on alternative services, A&E and emergency call-outs leading to enhanced long-term costs and patient dissatisfaction
- Loss of training opportunities for future healthcare practitioners including GPs in a surgery whose ethos is valued by the local community
- Loss of research and university connections that have been established over time
- Loss to the Devonport community of £1.4 million pounds invested in the Cumberland centre including the surgery area for the direct benefit of Devonport residents
- Potential loss of life

Barriers to accessing alternative services identified by existing patients/stakeholders:

- No patient choice
- Low accessibility
- Lack of trust
- Anxiety
- Previous experience
- Lost therapeutic relationships

Appendix 2

Community attitudes towards the Cumberland Surgery

- An “invaluable resource on a local level” for vulnerable adults and the local community
- “Model of excellence”
- Easily accessible / High quality service
- “A much needed facility”
- “ A pillar of the community”

Concerns regarding NHS arguments identified by patients and/or stakeholders:

- **The GP premises within the Cumberland Centre are very poor for modern healthcare:** The PPG wrote a letter (Appendix 1) detailing their disappointment at the delay in addressing issues identified with the two GP consulting rooms and not the entire GP premises as suggested in the above statement. Beyond the consulting rooms, the surgery is considered by patients to be light, spacious and modern. The PPG and others have identified a number of alternative rooms available in the Cumberland centre that could be used to address the issues raised with limited or no cost. If adopted, the surgery’s ethos, established relationships and local community networks located within a hub of local services could continue to develop with minimal disruption to existing and future patients. The PPG has also proposed moving into the Devonport Health Centre building but continuing to practise as the Cumberland Surgery with no merger.
- **The surgery serves relatively few patients, which, with a national shortage of GPs, makes it very difficult to recruit:** The Cumberland Surgery is currently responsible for training future GPs. With the surgeries unique teaching and research ties to the local university, the surgery is in a favourable position to not only recruit GPs to the local surgery but to also encourage GP training and subsequent recruitment nationally. The Cumberland’s strong links with the University and its innovative approach offer a variety of portfolio careers, making it easier to recruit to than many other practices. Furthermore, since it’s opening in April 2013, the surgery’s patient list has continued to grow. Prior to the letter detailing its closure, the surgery had one of the fastest growing patients list in Plymouth. This is likely to increase with the proposed regeneration and subsequent housing developments in the Devonport neighbourhood. Expected population growth will exceed the capacity of one GP surgery (e.g. http://www.plymouth.gov.uk/housing_by_neighbourhood3.jpg) to meet the population and service needs of the Devonport community. Historically there have always been (at least) two GP surgeries in Devonport representing an evident need. The campaign to keep the surgery open has also attracted new patients to the service highlighting its attraction to the local community. The expected population growth and subsequent need of Devonport residents has not been considered in the equality analysis.
- **Both the above factors would make the surgery unattractive to potential bidders:** This statement is not supported by empirical evidence or past experience and is therefore ill supported. For example, following the withdrawal of an existing contract by Livewell, Access Healthcare took over the contract despite the surgery having a smaller patient list than currently available and existing consulting rooms. Access healthcare have also showed their support in supporting the Cumberland for an additional year up until March 2018. Potential bidders have not been provided with the opportunity to bid for the Cumberland Surgery. This statement is therefore ill-informed.
- **Everyone who goes to the surgery is registered with the single practice, so would, as now, be able to use any of the other three surgeries without re-registering:** The majority of patients who have attended local PPG meetings or NHS ‘drop-in’ sessions have voiced their concerns regarding accessibility (Appendix 2). 37-66.9% of Devonport residents do not have access to a car or van (http://www.plymouth.gov.uk/plymouthreport.pdf). No direct bus routes are available between Devonport and Ernesettle or Mount Wise. The practice looks after a high proportion of homeless patients and those with complex needs. This holds serious implications for patients accessing the alternative surgeries suggested. Despite this, discussions regarding transportation difficulties and subsequent costs are not present in the NHS equality analysis raising cause for concern.
- **Anyone who uses the surgery would alternatively be able to re-register with the new, purpose-built Devonport Health Centre next door:** patients identify a number of reasons why this alternative is unfavourable (Appendix 2, 3 and 4). Patients hold little faith that a new building ensures quality of care. In

any case the building housing the Cumberland Surgery is also considered purpose built for local residents and patients following the investment of £1.4 million Devonport regeneration money. Patients point out that they did not ask for the Devonport Health Centre to be built. Patients have made a conscious choice to register at either the Cumberland Surgery or Devonport Health Centre. If they wished to attend another service they would have already done so. This choice should be respected and upheld.

- **Other practices in the area are also willing and able to take extra patients, so nobody would be left without a doctor:** comments added to the online petition (appendix 4) by both patients and GPs at other practices in the area suggest alternative services are already over stretched or near 'capacity'. Patients and stakeholders alike question the validity of this statement. Capacity assessed on surgery size alone offers a reductionist and potentially dangerous assessment.
- **There are real benefits in being part of a larger practice, with greater choice of appointments, more services and a wider range of skilled staff:** The benefits attributed to a larger GP practice are ill-supported in existing literature and by patients themselves. Although not all, many patients value the intimacy and community centred ethos of a smaller GP practice and make a conscious choice to attend these services. Some patients interviewed reported a likely increase in anxiety if they were forced to attend a bigger surgery. Many of the Cumberland Surgery patients suffer from complex mental health needs that may be exacerbated by increased anxiety. One contradiction in this statement is that the Cumberland Surgery is part of a larger group practice. Thus, the benefits of a larger practice proposed in this statement were therefore already available to patients with the added benefit of operating in a small GP environment. Patient choice appears to have been overlooked in this statement. This is possibly as a result of failure to engage with patients prior to the publication of the equality analysis.
- **Services at the premises were never contracted by the NHS, but were provided on its own initiative by Plymouth Community Healthcare:** Devonport is the most deprived area of Plymouth producing the lowest life expectancy scores and highest rates of disease and disability in the city (Appendix 5). In an attempt to address these inequalities, a new GP practice was set up in collaboration with Plymouth Community Healthcare and Plymouth University. Both partners signed a memorandum to *"work together to improve the health and wellbeing of the population, reduce health inequalities and address ill health through prevention, promotion and innovation via community services in ways that will transform the health status of individuals within their community".* This memorandum has been met by the Cumberland Surgery and should be able to continue to do so irrespective of who originally contracted the GP surgery. For example, the surgery works very closely with Devonport House Salvation Army hostel, George House hostel, Shekinah mission, Harbour drug and alcohol centre and Hamoaze House rehabilitation centre. In these and many other ways Cumberland Surgery has fulfilled its goal of transforming health care for some of the most needy in the city and challenging health inequalities in Plymouth. What remains as a direct result of the original partnership between Plymouth University and Plymouth Community Healthcare is a successful, valued, and actively engaged GP surgery making an evident difference to the lives of the community it was designed to serve.

Evidence quality – validity and reliability of equality analysis

- The equality impact assessment is not based on rigorous primary research or empirical evidence and shows clear signs of bias. The equality assessment submitted is a plagiarised lift of the report submitted by the Plymouth Council back in 2014 (http://www.plymouth.gov.uk/devonport_neighbourhood_profile.pdf) with no references provided. No research, data, or evidence beyond this single report has been considered. Reliance on one publication is not considered good research methodology and undermines the validity, reliability and accuracy of the assessment provided.
- The equality impact assessment form asks for "*List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic)*." References are not provided for this at any point nor are any indications of "*national research, surveys, reports, research interviews, focus groups, pilot activity evaluations or other Equality Analyses"* conducted to determine the impact on any equality group as requested undermining the validity of conclusions drawn.

Appendix 2

Those who think the closure is a bad idea:

"We've got a situation here where we've got the worst health in the city, a practice that is making a difference and is growing when you can't get GPs for love nor money, anywhere else, we've got the whole of the council, the director of public health, the university, all the patients, loads of patient representatives all saying we don't want this to happen and if the purchasers still go ahead and do it then they don't care about any of that, local democracy or the patient voice" PPG meeting attendee

- Patients
- Practice staff members and GPs
- Other surgeries
- Patients at other surgeries
- The Patients Association
- Local Councillors and Council officials
- Local MP
- Local services who rely and value the services provided including the Salvation Army, Shekinah, and Help for Heroes.
- Medical students
- Medical School teachers
- Dean of the Medical School
- University researchers
- PCC
- The Director of Public Health
- Members of local community organisations
- Members of local churches
- Over 1000 petition signatures

Areas patients and the NHS can work together:

1. Alternative consulting room space identified at the Cumberland Surgery and the surgery, be made available and the surgery, its ethos, patients and staff continue business as normal. The surgery would then go out to tender.
2. The Cumberland Surgery as it currently exists moves into the alternative space at Devonport Health Centre and continues to practice independently as Cumberland Surgery with no merger. The surgery then goes out to tender.

Comments from Services associated with Cumberland, Hyde Park and St Barnabas Surgeries

CUMBERLAND SURGERY

GEORGE HOUSE HOMELESS CENTRE The surgery works with the centre staff to find out what works best for our client group in terms of progression. The location of the practice at Cumberland is ideal for George House and we are also visited by the outreach service. (**GP Name redacted**) is forward thinking and looking more holistically at care provision for the client. He has a high level of elastic tolerance, is creative and thinks differently. We have concerns if the Cumberland Surgery was to close as the level of tolerance required is high and other practices don't want to take on our client group.
SHEKINAH MISSION Shekinah Mission have recently run consultations with service users from both their own project and Hamoaze House. Many of those consulted have multiple and complex needs. The following statements from their report are relevant to the Cumberland Surgery. There seems to be a widening disparity between GP practices across the City. The Cumberland Centre GP practice seems to have scored quite highly in terms of accessibility, compassion of staff and various health practitioners being co-located on site giving easier access to care. Another GP based in the same geographical area is cited as not being worth bothering with due to, perceived, lack of concern. *'We need more integrated services; have a number of professionals under the one roof.'* And, *'Deeply underfunded; lack of integration.'* The Cumberland Centre seems to be working towards this model with some success, however, there are still only health services on site; no social care or third sector input.

HYDE PARK SURGERY

CHATSWORTH HOUSE RESIDENTIAL CARE HOME Chatsworth residential home would be gutted to lose Hyde Park surgery because it is such a well-run surgery--they are efficient, attentive, polite, and helpful, I could go on and on. We know that when we contact this surgery they listen and offer a really personal service that our residents would not get anywhere else and I know this because we have odd residents at other surgeries as it is their choice and the service from the other 5 surgeries does not even come close to Hyde Park. All you hear in the news is how over stretched surgeries are and yet you want to disperse 3000 patients to other surgeries that I am sure would not cope. Recently Glendower surgery closed and so their patients were also dispersed amongst local surgeries and now you want to add on top of that. (**GP Name redacted**) is an exceptional doctor and we do realise he has to retire at some point but he has built up a brilliant service from the nurses, to the receptionist (and you can't say that about too many Drs receptionists), to I am guessing his cleaners (as his surgery is always spotless). I think any other GPs would be proud to take over and keep up the excellent reputation of (**GP Name redacted**). Most of my residents have Dementia and so familiarity is important to them, I know with larger surgeries it is pot luck which GP you are going to get if they agree to come out at all. It feels like surgeries are expected to be much larger these days and really modern, I know Hyde Park is not the most modern of places but it is really calm, they have an excellent system down there which makes things tick over really smoothly. If we are concerned about a resident we dip their urine and if positive take a sample to the surgery and it is dealt with that day, any of our other surgeries we have

to keep chasing and chasing for days which does not help the resident as their confusion and often mobility becomes much worse while we are waiting for some form of treatment. The same goes for prescription requests—these are dealt with within 24 hrs, again with other surgeries we have to make repeated calls to chase them up.

We feel at Chatsworth that closing Hyde Park is jeopardising the health of our residents.

CHARLTON HOUSE RESIDENTIAL CARE HOME

We were saddened to read the news when we received a letter in the post - sadly we were unable to share our views and support the surgery at the first consultation meeting as we received our letter some days after however we made our views very clear to (**GP Name redacted**) who kindly gave us the date and time of the next consultation meet 12/9/2016.

So we would like to tell you what Hyde Park surgery means to us at Charlton House and why the service they provide is invaluable and would be greatly missed if the surgery were to close.

Hyde Park have been a constant in the running of Charlton House - our longest serving surgery which means that we have built relationships and rapports with all the staff members that work there.

Our residents who are registered at Hyde Park (half of the 44 we have) have continuity of care because of the relationships we have built but also because of the GPs professional yet informal approach to the care of our residents.

Charlton is registered with nine other surgeries however the services they provide do not feel as tailored to the needs of the residents as those provide by Hyde Park for example:

- The GPs quite often pop by after clinic if they have concerns over any results they have had back for a resident or just to see how they are if they have previously been unwell even if during that time they had already been for a house call.

- Prescriptions are always on time, monitored and reviewed regularly by the GPs at Hyde Park. We never have any issues with medications being late or unavailable. If the surgery is unable to EPS the script to our pharmacy because it is too late they always communicate with us and we go to collect and have it dispensed at Hyde Park pharmacy down the road.

If there are issues with ordering medications for example and item is no longer available from the manufacturer the surgery always communicates this with us and we work as a team to find a suitable alternative that can be prescribed. This relates also to the nurses we have who come to Charlton - everyone communicates the residents care needs to make sure that there is continuity but also that all members of the team including families and the resident are happy with the service they are receiving.

- We are a St Lukes accredited home and provide end of life care at Charlton House and liaise with the surgery regularly if we have a resident who has been diagnosed as EOL. The GPs are always available for advice and a visit even if it's just to look over the resident or speak to the family. Just in case, medications are always prescribed promptly and because they know their patients and our team so well when a patient declines they trust and listen to the teams concerns and take into consideration the information they have been told when making a decision about treatment. We believe by taking all aspects of information given this provides an holistic view of the patients' needs and a higher standard of care is provided - something Hyde Park and Charlton House take pride in and something everyone deserves especially in their last days.

This is just a snippet of the service that Hyde Park provide to Charlton House if we carried on then the list would be endless! What makes Hyde Park so special is the same reason that it could potentially be closed for in that it is a small practice but critically has all the elements the larger practices are missing with a family feel and continuity of care with GPs and a team that go that extra mile to provide a standard of care that everyone deserves and is entitled to but sadly all too often these days do not receive.

TOWNSEND HOUSE EX OFFENDERS HOUSING SUPPORT

When I managed Townsend House I was always reassured that the medical needs of complex patients would be managed. Not only would they be managed but they would be made to feel a part of the community and valued. There are several ex residents that I still see today who maybe wouldn't have got so far if it wasn't for your surgery's care and support.

HYDE PARK SURGERY ANTE NATAL SERVICE

I am the allocated midwife for Hyde Park Surgery and I provide all antenatal care for the pregnant women. I am currently able to give continuity of care to the local women, which is essential, especially for those with mental health or safeguarding concerns.

The caseload is large for the size of the practice and I have concerns about the women becoming vulnerable and unable to access appropriate care if the surgery closes. Appointments are already at a premium and if women have to attend another surgery with ever increasing caseloads it could put the safety of the mother and her new-born baby at risk.

I have spoken to the patients that I have seen and they value the service that they currently receive. Also our Friends and Family Test supports continuity of care and we see an increase in complaints when this is not possible. The patients deserve a service where there is safe and effective care, with a personal service in the area that they live and Hyde Park Surgery provides this in abundance.

ST BARNABAS SURGERY

NORFOLK VILLA RESIDENTIAL CARE HOME

We at Norfolk Villa, have used St Barnabas Surgery for some 20 years with (**GP Name redacted**) and now others. It is convenient but not unique and we shall be able to cope. It would be preferred that the surgery was to remain open but we understand the general lack of funds available and shortage of staff.

We generally hate change but see some of the problems. Everyone wants the NHS to succeed but few want to pay. Perhaps, if the Government would stop setting targets and standards we could all do our job to the delight of the public. Too much form filling and red tape. It can be counterproductive.

PARKWOOD HOUSE NURSING HOME

The following is a summary of a telephone conversation with management.

Following (**GP Name redacted**) retirement, the home and patients experienced a rude GP and therefore after consultation with patients and their families, all patients that were previously registered at St Barnabas under (**GP Name redacted**), have since been registered with a new GP at a different location.

ST BARNABAS COURT

The following is a summary of a telephone conversation with management.

Whilst unhappy with the service since (**GP Name redacted**) left, their patients remain registered as it is close by and should they have to register their clients elsewhere it is likely they will have to request more home visits due to distance and are conscious that this will only put a strain on NHS resources. Their recent experiences of the surgery have not been great, where requesting a home visit to a resident with a suspected inflection, they have had to wait 3 days for a home visit, which in turn has placed pressure on their internal infection control procedures.

TWO TREES CARE HOME

The following is a summary of a telephone conversation with management.

Since the retirement of (**GP Name redacted**), there had been a series of issues concerning prescriptions with items missing, having to chase the surgery to send the prescriptions to the pharmacy and problems getting appointments or home visits and being spoken to rudely by staff. Where there was a home visit on one occasion, it took a further two weeks to get the necessary prescription for the medicine prescribed due to delays from the surgery to the pharmacy.

Comments from Patients and Patient Groups

CUMBERLAND SURGERY

26/08/16	Following your request we share our views on the proposed closure of our surgery I would like to share my points as follows: The surgery is very valued by myself, partner and our young baby. We do not have any issues with obtaining appointments, the receptionist staff are extremely helpful and all members of the medical staff are second to none. We have built up a good relationship with these staff and I am absolutely gutted I may have to change surgeries and start again and am worried I will not receive the first class service that I have become accustomed too. I have not heard any good reviews about the surgery next door and feel by making us transfer to another surgery my care and my families care will be greatly adversely affected. My questions with regards to the surgery next door is are they planning to increase their staffing levels to cater for all of the current patients? Do they have adequate resources to deal with the patients many who are vulnerable? As we know Devonport has a rather negative reputation and the council and doctors here at Cumberland work with vulnerable challenging people to help improve the area as well as ploughing money in to the community with new homes and schemes in an aim to make it a better area to live. This has been working and feel with the right support people who are homeless or addicted to drugs are getting the support they need. If we lose this surgery will the support drop? I am worried if it does then this will have a negative impact on these people which in turn will have a negative impact on people like myself and my family. With regards to increasing the population, houses are constantly being built, will the surgery next door cope? If not why should we have to travel out of area to see a doctor? Many people do not drive and especially if poorly you do not wish to travel far to see a doctor or nurse. I understand the premises are not state of the art however they are fit for purpose, a room with a bed, chair, computer and doctor or nurse is all that is needed. You attend a doctor or nurse when you are unwell, you need to be listened to and examined, that's it, what more do we need? I am extremely disappointed that this proposal has been made and if it goes ahead will take away my choice in health care and as stated above have a negative effect on both mine, my families and our communities health. I do hope our views are listened too and not ignored. I will do anything I can to save this wonderful surgery.
07/09/16	I was mortified to hear that Cumberland Surgery might be closing, there are many people like me that like small surgeries. I left (**GP name redacted**) Surgery because I wasn't happy with it, I certainly will not be going back to there. I can phone the surgery and they know me, I am not just a name they know what's wrong with me, I don't have to start from the beginning all the time. It's not just the practice nurse or the doctor it's the whole thing the atmosphere is lovely when you go down there. (**Name redacted**) the practice nurse is brilliant she will explain things to you and put you at ease. (**GP Name redacted**) works with the Salvation Army, Shekinah Mission and the homeless has any one spared a thought for them what's going to happen to them. There was a man from Salvation Army who was telling me if it wasn't for (**GP Name redacted**) and the last 4 mths that he has worked with him he might have been dead by now or in a park in a heap he was nearly in tears. My son also goes to (**GP Name redacted**) my son has a lot of problems for me to have to try to get him to go to another surgery is going to be impossible. My son has a phobia with needles (**Name redacted**) is the only one that can do it she knows exactly what to do, if I told him someone else was going to do it he wouldn't go. Seeing as Dr Nash has about four and a half thousand patients and (**GP Name redacted**) has about two thousand and there is more Doctors in (**GP Name redacted**) surgery that's got to tell you something and there is people even now that want to join (**GP Name redacted**) (Cumberland) surgery. So I am begging you please don't shut the surgery give him the help he needs to grow.
07/09/16	My name is (**Name redacted**) I have been a patient at the Cumberland Surgery after leaving (**GP Name redacted**) if you shut this place down I don't know what I will do. I have arthritis in both knees and can hardly walk (**GP Name redacted**) is ideal for me. I am very happy with the service I get at the surgery I wouldn't want to go elsewhere.

07/09/16	Just to say please don't close the surgery I need it I 've never felt more comfortable at a Doctors Surgery
08/09/16	The Cumberland Surgery serves some of the most disadvantaged households in Plymouth. Its patients include many residents of homeless hostels and other vulnerable people who are angry and distressed at the possible closure of a facility that supports them so well. The NHS aims to give choice to patients, so please give the people of Devonport a choice of GP practice. It is not realistic to say they can remain registered with a partner surgery a bus ride or more away. Timely attention to health problems is likely to be replaced by use of emergency services. It is no consolation to hear that the cost of paramedic calls, A&E visits or hospitalisations comes from a different budget. It is all coming from 'the public purse'! The Cumberland Surgery is not, despite indications to the contrary, served by a single GP and it is, moreover, part of a large (approx. 12,000 patient) multi-location group practice. It is only small by the definition of the current plans which have broken the group practice into 'lots' and disregard the fact that it is a new surgery whose patient list has grown from zero to almost 2000 patients in three years. Fragmentation, like privatisation is a death knell for the NHS. This is no ordinary surgery; it was set up as a joint venture between the then 'Plymouth Community Healthcare' and Plymouth University to "work together to improve the health and wellbeing of the population, reduce health inequalities and address ill health through prevention, promotion and innovation via community services in ways that will transform the health status of individuals within their community". Numerous medical students have been trained there, many being 'infected' with the passion to follow a career as a GP. With a desperate shortage of GPs, we need to be encouraging this opportunity, not taking it away. The surgery is also participating in medical research that is important locally, nationally and internationally, with delegations from as far afield as the Middle East and North America coming to see the ground-breaking teaching and research work happening on our doorstep. No one doubts the pressure on NHS funds. But everyone seems hidebound by the model for GP services that removes any leverage that can be exerted to serve communities in the best way possible. So please, NHS England, draw on the collective wisdom, creativity and resources available to find a solution that preserves all that is good in the Cumberland Surgery. The people of Devonport will thank you.
13/09/16	Yesterday at a drop-in session at the Cumberland Surgery HNS England wanted to hear our views about the proposed closure of the surgery. It was apparent from the tenor of the conversation my wife and I had with the NHS England representative that NHS England have already made up their minds that Cumberland Surgery will close. They only attend such drop-in sessions to give the impression that a proper consultation process is taking place. However, through the Practice Patients Group Cumberland Surgery is mounting a strenuous and well thought through case for its continued existence. I would suggest that Healthwatch Plymouth contact the chairman of the PPG, who can provide copies of all the documents which have been prepared making the case for the surgery's continued existence. The MP for Plymouth Sutton, Mr Oliver Colville is also involved in the efforts to save the surgery, he also should be contacted. From a patients perspective the surgery is better placed than many in Plymouth based as it is in the Cumberland Centre where several medical facilities are also based. This puts the surgery in a 'medical' setting and is in the nature of a 'polyclinic' or 'one-stop shop'. The doctors and nurses provide the highest quality care, especially so as their 'bedside' manner is second to none. I say this with experience of other surgeries in PL1. Appointments are available either same or next day, unlike the 3 week wait at other PL1 surgeries. The Cumberland Centre building is run by Livewell South West who are obstructive towards the Cumberland Surgery. They are preventing the Cumberland Surgery using presently un-occupied space in the building, despite the fact that the building was provided by Devonport from their re-generation fund

	(£1.4M). Livewell are simply managers, the directors of Livewell need their heads knocking together and told to stop being petty. The strong link between the Plymouth medical school and the surgery is provide by one of the surgeries GPs, (**GP Name redacted**), who is a lecturer at the school. This is a valuable facility. I would be happy to remain in contact with Healthwatch Plymouth if this would assist in keeping the surgery in existence.
13/09/16	Please accept this email as one of complaint and extreme disappointment with the process concerning the Cumberland Centre in Devonport, Plymouth - particularly as I have only just received my letter of notification. I feel that as a patient of the Cumberland Centre practice I have been 'hoodwinked' into this process which, when one notes that patients will 'alternatively be able to re-register with the new, purpose-built Devonport Health Centre next door' to the Cumberland practice, implies to me that the intention to close the GP practice at the Cumberland Centre was always on the cards! This does not in any way feel like a consultation process. I am fully aware of the guiding principles of consultations, i.e. should provide sufficient information to ensure that the targeted groups can make informed decisions, which includes the impact of any proposals on the intended group, business, locality, etc. Furthermore, consultations should consider the target groups, in this case 'patients' - not all patients will be able to drop everything they are doing to attend a meeting on a Thursday during Summer school holidays. There may be patients with mobility, literacy, language, care issues, etc. that simply could not easily attend. Furthermore, consultations should also be for a proportionate length of time - I cannot see how this meagre exercise can seriously be regarded as a consultation of a proportionate length of time! This to me, is more a PR exercise! The Health & Social Care Act 2012 placed duties upon CCGs and NHS England to commission health services for all of those people for whom they have a responsibility, which includes those who are provided with medical care and resident in the area, and for health inequalities to be tackled. I do not believe that manipulating people to move out of area to register with a GP, is appropriate. The letter I received today mentioned 'real' benefits of being part of a larger practice - but there are also disadvantages. How does this work in terms of accessing a GP, particularly when there is a national shortage of GPs? Is it right to assume that there is equally a shortage of GPs for Plymouth? Are no GPs wishing to work in Plymouth, if not, why not? Why are so many existing GPs giving notice to quit? Whether or not patient choice is relevant here, I want to mention it. Patients like to build an element of trust and faith in their GPs. Some will have built a good relationship with their GP at Cumberland - this proposal is going to have an impact on those patient's lives. And what about the men that have started to open up their GP? We all know how difficult it is for men (generally) to discuss health issues, particularly mental health issues - this proposal could set these men back years with addressing their mental health issues. There are many issues I would like to raise about the letter I have received - I will make my case tomorrow. Nonetheless, I wish to report to you that I feel this process has been severely mismanaged and the wishes of the public deeply misunderstood.
22/09/16	I suffer from bronchitis and asthma so if I had to wait at bus stops in the rain, wind or even hot sun it would be difficult. Right now I can walk to the Cumberland Centre and I have a good relationship with (**GP Name redacted**) and would be devastated to have to lose this. I am a pensioner and although in general good health I am not getting any younger and health problems generally increase with old age, so envisage my need to access my GP more frequently. I also find it easier to make an appointment in person rather than by telephone. Blood tests etc can be done here. I find it ludicrous that any suggestion to close GP services will benefit patients. This area is building new houses and rapidly expanding the local population, therefore more and more demand will happen. Young children, pregnant women, retirees will need medical services! The press recently announced Stonehouse Barracks is to be redeveloped - probably flats! The Royal William Yard is only half occupied, many derelict blocks, yet to be converted. My own environment is still growing, 6 storey blocks of flats under construction. Where will these occupants register for a GP when other surgeries are already overstretched? Houses once housing one family are being converted to multiple occupation eg Durnford Street. Millbay area is being developed. Government policy is to build build build. Need I go on? Every month hundreds of so called patients fail to attend their appointments. Fine all patients who waste GP time and

	services, no exceptions. Those on benefits, pensioners. Three fail to attend appointments and you are struck off. If I am to lose my GP surgery and associated services then drastic solutions are required. Chase payments for overseas visitors. If we are to keep our surgeries we should be ruthless in doing so. We need more surgeries, (not necessarily more services) some cosmetic procedures and non-medical privileges can be abolished. I might seem hard but I grew up in a household with a disabled father and sick grandmother. I worked in the NHS. I appreciate what I receive, but never take it for granted or demand more than I need. Nobody should introduce GP appointment fees.

HYDE PARK SURGERY

23/08/16	Re : Surgery Closures If by 'there are surgeries nearby' the NHS means Lisson Grove can I suggest they look at how long it takes to get an appointment sometimes and what the workloads already are. Even with new staff it is going to overload this busy surgery if Hyde Park closes. I would also be concerned about the distance elderly people would have to travel.....only half a mile or so more but, if you're not well and it's blowing a Plymouth hooley in the winter, that extra distance could be significant. I was brought up to believe that access to a Doctor should be local...not one every NHS defined distance.
25/08/16	Further to the meeting held at Hyde Park Surgery this morning to discuss the proposed closure of the practice I would like to voice my concerns over the manner in which the consultation has been organised: It became apparent that all of the patients at the meeting, about 50, had only received the letters informing them of the meeting yesterday. That is far too short notice and excludes university patients as it is the summer vacation for them. Many families are also away on holiday, this being school holidays and bank holiday week. (**GP Name redacted**) told us that there were 2,900 patients registered at the practice, not the 2,500 that the letter quoted and that nearly 300 extra patients had been registered since Access Healthcare took the practice on less than 5 months ago. The letter indicates that Access Healthcare would be unlikely to bid for the contract to run the surgery next year, but when pressed at the meeting, NHS England representatives refused to confirm this. As the surgery has expanded its patient numbers in the last 5 months, surely it is even more viable now than it was when Access Healthcare took it on? (**GP Name redacted**) told us that the problem of recruitment is a national problem, not peculiar to this practice, a fact that is borne out by reports in the media. (**GP Name redacted**) told us that he had enquired about the "other practices in the area willing and able to take extra patients" as quoted in the letter, and had been told by those 2 practices that they were full, had no plans to expand and furthermore knew nothing of the proposals to close Hyde Park Surgery. Many patients are elderly and cannot drive. Lack of parking is an issue for all surgeries in the area. People need a surgery they can walk to. The letter states “there are real benefits in being part of a larger practice". There probably are, but people I know who are patients in larger practices complain that they see a different doctor every time they visit who does not know them personally and does not have time to read through all their medical history before attempting to treat them. Older patients and mothers in particular need reassurance that the doctor treating them knows them well. A doctor who knows his patients well can identify problems with their health earlier and treat them far more cheaply and effectively. (**GP Name redacted**) cited the many services that the practice delivers outside the main GP appointments. Ante-natal, services to ex-offenders, University students, care homes for the elderly. The Mutley/Mannamead area is very densely populated and also has a large infant and primary school very nearby. Given that doctor recruitment is a problem, who will take over these services if the surgery closes? Making access to a GP more difficult by closing surgeries will inevitably put more pressure on hospitals that already struggle to cope, incurring far greater costs both financially and to peoples' health and well-being. Local GPs help keep people out of hospital and treat them at far less cost.

30/08/16	I am writing to register my opposition to the proposed closure of Hyde Park Surgery, Plymouth as proposed by NHS England. I gather this proposal is a bid to save money. Although NHSE claims to want to make the best use of taxpayers' money, they need to appreciate that health should come first. We have been told by NHSE that small practices struggle to offer extended services and opening times. This is simply not the case. At Hyde Park there is a wide choice of appointments, services and skilled staff and there is a full complement of doctors too. The GP and Nurse clinics are fully staffed, unlike Mount Gould and Ernesettle (both not due to close) which struggle to cover all clinics. Hyde Park provides excellent personal care that is not possible with larger 'value for money' practices. Indeed, I left Lisson Grove as I was fed up of never seeing the same doctor twice in a row, and felt that a small, 'family' style practice would be much more helpful. I found that I actually know my GP and nurses in Hyde Park because it is a small practice, and this has been so important, particularly in relation to my teenage son who has had mental health concerns. We also rely on the surgery knowing us well, for the management of our asthma. We were told that it is becoming difficult to recruit GPs. This is a national problem, and NHSE should already know this. If people hadn't become so disillusioned with working for the NHS, there might not be such a shortage of people to fill these posts. Too much damage has been done to the health service lately - unacceptable treatment of junior doctors and the axing of bursaries for NHS students in 2017. If unwell I don't want to have to go to a surgery that I would need to drive to, or get the bus to. A long walk is also not appropriate if a person is unwell. Elderly and less mobile people will struggle in particular if they are moved. If this plan goes ahead, my octogenarian father in law will be on his third GP in 4 years (Glendower Road closed recently). I have had no reassurance that local surgeries will have space for new patients if Hyde Park closes, and am concerned that a large influx of new patients from Hyde Park will put further pressure on other practices and it will become difficult to get an appointment. I gather that Hyde Park's list size is approaching 2900 patients - other surgeries which will remain open have less than this e.g. Mount Gould, Trelawney. Hyde Park Surgery is a going concern and there appears to be no good reason to consider closing it. This business led approach can only harm patients. Hyde Park Surgery needs to remain open for the health of local babies, children, teenagers, adults and elderly people, and in order to not put further pressure on other surgeries.
31/08/16	It was very satisfying to see so many attending the meeting at the surgery last week and in view of the lateness in being notified of this meeting very gratifying to know the strength of feeling amongst the patients of (**GP Name redacted**) and their views re the closure As you will recall the information in the information sheet sent by NHS England was full of wrong information which was rectified by Dr Warren and my reason for contacting is to state that hopefully you took on board all the wrong details that a are being circulated by NHS England and ensuring that the correct details are being sent to the relevant people. If NHS England are so wrong about such important detail then how many other mistakes are being made and circulated to ensure that these closures go ahead, I am sure you were aware that patients are more for the personal care given in a smaller practice and do not wish to be lumped into multi practices where you are a number as against a person. The statement made, which NHS England deny making, although on a letter from Mr Colville to me quotes them as saying that it is safer for patients not to be. In single practices so that their colleagues can keep an eye on prescription allocation has now appeared in the local press. This remark was made by someone but as usual is being bounced from one person to another, but in any case is most insulting and in my view tantamount to slander However there is a second meeting at Hyde park this coming Friday so no doubt one of your representatives will be in attendance to report back to the relevant body how strong the feeling is against closure of Hyde park surgery.

04/09/16	We none of us are going to go away quietly just because Jeremy hunt thinks he can slowly get rid of the NHS. All he is doing is taking Tory supporters into other camps. Hopefully you gave got the message that we do not want to be limped into a multi practice where the same doctor is not seen twice and patients are nothing but a name in the book. Hyde park practice is a very personal, friendly practice and treatment and care is second to none. Having been in the practice, including my children and now my grandchildren for many many years I think to close this would be an absolute travesty. The letter that NHS England circulated one day before a meeting was full of many many wrong statements which thankfully (**GP Name redacted**) was able to correct and I just hope that the right info is now in the hands of those who think they are able to play with the health of the nation, i.e. Jeremy hunt and the prime minister who seems to be allowing him for rein to do as he wishes. I know I have written all this previously but want to endure that you all realise we are not going to sit down and let you all have your own way
04/09/16	I wish to voice my concern at the possible closure of my doctor's surgery at Hyde Park. My family have been patients at this surgery for a number of years it has always been exceptional in its delivery of healthcare services and caring for patients. The reasons that my surgery is vulnerable and not viable given do not add up as it is fully staffed, has good practice numbers and is a going concern. It is my opinion this is just excuses for cost cutting where saving money is the priority not patient CARE. It is important we keep this surgery open and its future protected.
04/09/16	As I have only been a patient at this surgery for a matter of months I may be deemed less qualified to make a comment on its proposed closure. But I hope that after reading my story you will feel that actually my experience makes my opinion particularly relevant. For over 40 years I was a patient of what eventually became Collings Park Medical Centre in Eggbuckland, Plymouth. The practice nearest to my home in Hartley, Plymouth. When I first registered there it was a 'one man' operation run by a single GP (the legendary (**GP Name redacted**)) who held surgeries in his home at the top of Cranmere Road. He eventually took on a couple of partners, (**GP Name redacted**) and (**GP Name redacted**) and when he retired the practice moved to its current premises. Over the year it grew and different doctors came and went. There did appear to be a swift turnover of staff at one point and there is no doubt that some GPs were much more approachable than others but we always felt confident we could get an appointment if we needed one and the care we received was the best the NHS could offer. Much as Hyde Park surgery is now. All my family have been patients there and my daughter and her children are still registered as patients (although they now share my dissatisfaction and were looking to move to Hyde Park until this recent 'consultation' process was instigated). It is difficult to pinpoint exactly when we noticed a distinct change in the standard of care provided by Collings Park and an increased difficulty in getting an appointment. It was probably a gradual deterioration and as, in general, we are fortunate enough to enjoy fairly good health visiting a doctor was not something we had to do often and we were not necessarily aware of what was happening – such as a take-over by a larger health group. In recent years, however, that deterioration has become far more rapid and noticeable My husband reckoned the only way of being sure of getting an appointment was to go and stand outside the door and wait for the surgery to open. Not always an option if you are not feeling well (usually the reason you want to see a doctor) and certainly not ideal if you are a mother with young, poorly children. If you did strike it lucky and get to see a GP the standard of care was, to put it mildly, inconsistent. There was virtually no continuity with a merry-go-round of GPs. Occasionally you would be lucky and see a GP who treated you with respect and care. Frequently you would leave the consultation feeling you had wasted the doctor's time. At the end of last year I suffered from a constant, debilitating cough for almost six months. Bearing in mind that a Government funded advertising campaign urges you to seek medical help if your cough goes on for longer than 3 weeks I sought a GP appointment. Easier said than done and a stressful exercise in itself. I had to make three visits to my doctor to get any kind of investigation and only then because I pleaded for an X-Ray. One doctor, (**GP**

	Name redacted), was so dismissive he made me feel like a hypochondriac and reduced me to tears. My daughter wrote an official letter of complaint because she was so upset by the way I was treated. I was fortunate. The cough turned out to be a nasty and prolonged virus and I have now made a full recovery but it could have been a very different story and had I been able to see a GP earlier who was prepared to make a proper examination I am sure this could have been established much sooner and put my mind at first much earlier. Things finally came to a head for me a couple of months ago when I was feeling particularly poorly and decided I needed to see my GP. I began dialling the number at 8 am (I didn't feel well enough to do otherwise, i.e. turn up in person in the hope of getting an appointment) and after almost 20 minutes of a constant engaged tone got through to a receptionist who told me there were no appointments at Collings Park that day. I was offered an appointment at the sister surgery in St Budeaux at 4.15 pm but in the split second it took me to hesitate over whether I would be able to get to the other side of the city at that time the appointment disappeared from the system and I was told the only alternative was to try again the following day. It was at that point I decided enough was enough and I would find a new GP practice. I approached my other local surgery at Mannamead but was told their list is now closed to new patients. A great many friends and close acquaintances recommended I try Hyde Park Surgery. They gave it glowing references and reviews saying that I would be assured of good quality and compassionate care. It would seem there are several very happy and satisfied patients there so I decided to register. Within a couple of weeks I had cause to see a GP and all their predictions proved to be true. I got an appointment relatively swiftly, saw a wonderful lady doctor who treated me with respect and for the first time in years was made to feel I mattered as a patient. As well as dealing with the issue I came in with she took immediate action to resolve the cause of a longstanding health problem. She also reviewed the medication I have been taking for years and years for migraine, and made a few tweaks and changes which have resulted in instant improvement. I left feeling extremely pleased that I had made the decision to change doctors. I told my daughter and she decided that she and her children would move to the practice also. And now this. I am devastated that there is a prospect that this obviously excellent surgery is to close. It appears to be extremely professionally run and providing exactly the service it should. And of course it poses the question that if it does close what happens then? Where do I and all the other patients go? There will be even more pressure on other GP practices already struggling to cope. We will all be forced to register at larger practices where battling for an appointment is a stressful lottery and you ae lucky if you see the same doctor twice in a row and then only for a few pressurised minutes. Those unable to get a GP appointment are far more likely to then resort to A and E - already crippled by the sheer weight of numbers of people who report there in desperation. No prizes for guessing why. Is this really a wise use of resources? I think not. I was told at the consultation meeting that this is not a cost-cutting exercise; just an effort to make things operate more efficiently. I completely fail to see how forcing smaller surgeries to close is more efficient ...or for that matter more cost effective. Patients who enjoy the care of a good local GP are more likely to be healthy, issues are more likely to be picked up more quickly and dealt with at an early stage and ultimately that will save the NHS money. Closing Hyde Park Surgery seems extremely short sighted but I couldn't help feeling that it was a foregone conclusion. That the 'consultation' process was just going through the motions. A waste of resources in itself. When I arrived I spoke to a lady who told me she was employed by NHS England. She told me that over the years the structure of the local body administering our NHS has changed several times (presumably each time at great cost. New administrations, new logos, and new letterheads etc etc.....) If resources poured into constantly rejigging the administration was actually directed to the sharp end where they are actually needed we probably would have a far more efficient and healthy health service and a healthier population. When I was talking to her she obviously wasn't really listening properly. The whole time she was looking over my shoulder to see who else was coming into the room. When I told her of my excellent experience with the lady GP at Hyde Park she told me that doctor was now at Peverell surgery – the implication being that I should move there. I know nothing about the other practices under threat of closure as part of this consultation but the whole exercise makes me extremely pessimistic about the future of health care in Plymouth.

05/09/16	I have been a patient at the above surgery under (**GP Name redacted**) for more than 10 years. I left a big surgery, Lisson Grove because of all the things that has been encouraged to make us change from Hyde Park to a large surgery i.e.: more doctors, more appointments, and a wider range of skilled staff. I didn't find this so at all and I hear that that hasn't changed over the years. My brother is with Friary Surgery and he hasn't seen a doctor for years. He has phone in's. Not always the same day. Then if they decide you need to see a doctor you have to find an appointment which is another few days or as in my case more likely a week away. I used to think, you needed to know that you were going to be ill in advance!! Maybe that's what others thought and booked theirs, which is why, when you went for your appointment you watch a screen saying how many people had missed or didn't turn up for them!! The doctors' names on the board looked impressive but most were part time and half were at another surgery so in actual fact there wasn't a higher choice at all. My surgery has a lovely doctor who cares and listens. Another issue, when you are told "I only have 10mins" and " I can't be a mind reader" we have had other nice doctors who cover. The nurses are available and the reception staff great as well. Why would anyone want to go to a larger surgery which isn't as convenient to reach when we already have one and with enough patients to keep it going!?? Better equipped than others who are not up for closure. I totally disagree with this decision to the proposed closure of Hyde Park Surgery
05/09/16	I am very concerned about the proposed closure of Hyde Park Surgery and I understand that you are part of an organisation which can give people like me a stronger voice in influencing healthcare decisions. I'd like to object to the proposed closure because: - One of the doctors has cared for my family of five for over 27 years which has given us great continuity of care medically which would be lost. - We have always been able to get appointments whenever we have needed (routine and emergency) as well as ad hoc advice. The GP is even willing to ring me whenever I need him to, when I haven't been able to make myself free to call during the routine call-in times. I doubt if any other practices would do that. My mother was critically ill with another practice (reputedly a good one) in the city, but they were never that accessible even for someone desperately ill. - Four of us have long term conditions (seven between us) and we have always been able to access all of the specialist services we have needed through Hyde Park Surgery. (**GP Name redacted**) has even turned his hand to small surgery for me, which was a great success and stopped me having a long wait to be seen in hospital. - In all the time I have been with this surgery, all of the reception staff have consistently been helpful and courteous. Given that this has been achieved through so many different staff over the years, it must be a reflection of the ethos of the practice and their ability to select and train staff well. This is in sharp contrast to the feedback on NHS Choices for other practices in the vicinity, which regularly cite receptionists as rude, unhelpful and inefficient. - There is a relatively large amount of free, easy to access car parking near Hyde Park Surgery, which is not the case with many other surgeries in the area. - NHS Choices feedback gives Hyde Park Surgery an average 5 star rating, which no-one else in the area can offer. I think this undermines the argument that small surgeries cannot give good quality of service and I resent being deprived of 5 star quality and forced to accept something lesser.

	- I had extensive experience, over four years, of Chard Road surgery with my terminally ill mother, which is a large surgery, of the sort, so we are told that is more efficient than Hyde Park because it offers a wider range of services. I regularly had to wait for hours for my mother to be seen (only to be told all the GPs were out on visits), we rarely saw the same doctor, couldn't get through on the phone, we were treated like we were on a conveyor belt and rarely treated personally. None of this has ever happened to me or my family at Hyde Park Surgery, in over 27 years. - Much of the feedback on other local surgeries on NHS Choices gives the impression of practices struggling to cope with demand. You regularly see complaints about not getting through on the phone for days on end and not being able to get appointments, neither of which, incidentally, has happened to me at Hyde Park. Can the system really cope with one less surgery in the area, especially when, as I assume to be the case, Hyde Park Surgery has a lot of vulnerable patients? - The engagement process was, in my view, poorly managed. The invitation letter arrived with me on a Wednesday for a drop-in meeting on the next day (Thursday 25th August). This was extremely short notice and hardly likely to secure maximum engagement when it was during the holiday season (with many away) and during the working day (so those at work could not attend). I understand that as a consequence of complaints there has been another meeting arranged (12th September 2pm), but that this, too, is during the working day. I believe this is a gold plated, patient centred, highly effective surgery and it would be a tragedy to see it forcibly closed.
06/09/16	I am writing to offer my support to the growing concern of the possible closure of Hyde Park Surgery I am registered with the surgery and have been for many years. As a patient I cannot speak too highly of the care, consideration and compassion I have received from not only (**GP Name redacted**) but his team. I do not use the word 'team' lightly as this is what makes this practice so remarkable. The importance of the Francis Report which highlighted I quote 'many examples of appalling care is not the experience of healthcare to the vast majority of patients and their families.' I am shocked to hear that the safety of single handed GP practices (of which Hyde Park is not) is a risk to patients. Surely clinical governance and risk assessments ensure that measures are put in place to ensure high quality care is delivered. The 6 Cs: Care, Compassion, Competence, Communication, Courage and Commitment which should be integral to the care of patients has always been clearly shown in this practice. This in turn has undoubtedly helped numerous people stay independent, maximising well-being and improve their health and mental wellbeing. As a patient, I don't feel you can underestimate the value that is placed on individuals, families and carers from being registered at this practice. I am sure evidence would show a reduction in appointments, missed appointments and hospital admissions.
07/09/16	I am writing to register my opposition to the proposed plans to close Cumberland, St. Barnabas and Hyde Park surgeries but as I am a patient at Hyde Park I will concentrate on this surgery only. I believe that Hyde Park is a viable surgery offering excellent service and a level of care I have not experienced before, the GP and Nurse clinics are fully staffed and operate efficiently and effectively. There is a full complement of doctors. The surgery is convenient for patients affected by the recent closure of Glendower Road especially the elderly, patients with young children or people with problems mobilising. There is a car park opposite the surgery and an excellent chemist nearby. I understand there are approaching 3000 patents registered at the surgery which leaves me with real concerns that any attempt to "decant" the existing patients into other local practices will inevitably compromise the service to patients and lead to longer waiting times. I also know of smaller practices that are not threatened with closure. There is a large student population in the locality which is likely to grow who could be served by Hyde Park.

	I am appalled at the inadequate (less than 24hrs) notice initially given to patients by NHS England South West to attend the "consultation meeting" held at the surgery. I was unable to attend this meeting at such short notice and will be unlikely to attend on the 12th September so will have decided to write. I have also written to NHS England and Oliver Colville to ask them to fully examine all available options in order to save the surgery from closure.
12/09/16	Dear Healthwatch Plymouth Please find attached correspondence that relate to the planned closer of Hyde Park Surgery. I have attempted to draw to Ms Cory's attention the need to keep this surgery and why. In her reply she has failed to answer the questions I put to her and I will of course be writing back to her shortly. It appears however that despite the support of the local community and the MP it's still highly likely that the surgery will face closer. So the pressure needs to remain on Ms Cory to explain exactly which surgeries the patients from Hyde Park and possibly the other two surgeries ear marked for closer are supposed to go to. I don't believe that she has contacted any of the other surgeries to arrange a strategy for taking on the patients from the surgeries she wishes to close. She has failed to explain how the massive transient population of students will find a surgery as there will be a significant increase in their numbers next year. There is a large Student accommodation block being built right next to the old eye infirmary in Mutley which will be completed by August 2017. That's of course small compared to the massive 23 floor skyscraper at the top of town and the other sky scraper now being built behind the old cinema. In fact there are plans being considered to extend the university itself, this will bring in more students and staff and of course more student accommodation blocks. You will note the points I have raised in my letter to her and the fact she hasn't answered them, I would expect her to avoid such questions because her agenda seems clear but it will be to the determent of Plymouth. Hyde Park is an excellent surgery; it needs to be protected because Plymouth is expanding. It may not be expanding as quickly as some cities but development brings in more people and the current builds are significant. The other remaining surgeries will be under significant strain, I know that Stoke Surgery which was my previous surgery was swamped. Appointments always seemed to be late and my health concerns weren't probably investigated until I became a patient of Hyde Park. Despite Ms Cory's statement to the contrary larger surgeries don't necessarily mean a better service. Hyde Park is one of the best surgeries I've had the pleasure to be a patient at. No wonder it got a five star rating on the NHS's own website. If it closes a lot of people are going to lose a great practice which has dedicated itself to provide the best service possible, the most cost effective practice money can buy and it's capable of taking significantly more patients and there will be many more in the next few years.
15/09/16	Hyde Park is the best surgery about. It is a convenient location for me as my wife and I have no transport. We can do our shopping on Mutley Plain whilst visiting the practice for our appointment. They provide exceptional service, they are friendly and helpful. We are listened to and given time to talk. We get thorough examinations and are very caring. We get continuity and are able to see the GP that we want more often than not and they know my history without explanation. If we had to go elsewhere we would struggle as my wife can't walk and therefore we would have to spend out on having a taxi. We are both in our 80s. We used to be at Park View & Glendower and they were both rubbish! We were never examined, just talked to.
16/09/16	I have been a member of this surgery with (**GP Name redacted**) for over 20 years. I was previously with a surgery from birth. Going to the Doctors is not a pleasant experience for anyone as this usually would indicate that you have a medical issue. Sometimes it is difficult to be open and honest if it is a matter that you may find difficult to talk about. At Hyde Park, you are made to feel welcome, encouraged to talk about issues/health problems no matter how difficult as you are in a very laid back atmosphere. You are not made to feel like just a number but a person who is cared for. The thought

	for some people, including myself, having to build new relationships with strangers is a very unnerving thought. This Surgery is Central and very easy to access. My Husband, Daughter and Grandson are all patients at this Surgery as were my Mother, Father and Grandmother previously. Please do not take our practice away. You will hurt so many people in doing so and do people not suffer enough with all the other cuts which we have had to accept over the past 10 years without having to suffer another deep loss.
19/09/16	COPY OF LETTER TO JULIA CORY ALSO SENT TO HEALTHWATCH PLYMOUTH It does appear from your letter received regarding the above Surgery that this is purely an NHS England cost cutting procedure. Within the terms of your letter you appear to have prematurely decided that this Surgery is not viable and that we are purely a patient head count to play around with. You state that this is a small practice compared to others in Plymouth, (2,900 does not seem small), and there are smaller practices in Plymouth not marked for closure. WHY is this? Why would it be difficult to find any provider to bid for Hyde Park and that you are unable to force anybody to step in if they don't think the contract would make a make a viable business? Are other practices are willing to take patients? How can this be good patient practise to put extra pressure on other GP's, leading to longer waiting times to see a GP. Practices are paid per patient – it appears we have a price on our heads and that it does not take into account what level of care we receive. No doubt other local surgeries - as their websites claim are good, but do we just have to accept good and not excellent. You state the real benefits in being part of a larger practice gives greater choice of appointments, more services, and a wider range of skilled staff. The patient care received at Hyde Park Surgery is exemplary, how is it even possible to contemplate its closure. Putting unnecessary pressure and overcrowding at other GP surgeries in the area. This would no doubt lead to longer waiting times to see a GP, plus not knowing who your doctor would be. I have been a patient with (**GP Name redacted**) for 20 plus years, never ever had a problem with an appointment, the services and the range of skilled staff available at this practice are excellent. On a personal level, as a pensioner other local practices are so far away that I would have to taxi there and back. Due to my balance problems I am not independently mobile. I have not been able to venture outside on my own for nearly four years. My husband has to be with me or a neighbour accompanies me if he is at work. Hyde Park Surgery is my local GP surgery; the level of care I receive with (**GP Name redacted**) is amazing. Not knowing how far away I would have to go to find a GP practice to accept me is an unthinkable prospect.

	You state that no decisions have been taken and whether there might be other realistic options, your letter implies that this closure is a foregone conclusion and a cost cutting procedure. NHS England cutting GP surgeries should not be where the axe should strike.
19/09/16	I am writing to supply reasons why every effort should be made, including entering into the procurement process, to ensure Hyde Park Surgery should stay open. Hyde Park Surgery is a wonderful, friendly, helpful surgery. I have never been denied an appointment within a timely manner. I have friends who are registered with other local surgeries who have to keep some medicines back (such as antibiotics) as they know the next time they are ill they won't be seen quickly enough to get the medicine they need in time. Hyde Park enables us to be responsible patients and use the surgery in an efficient manner because we know it will respond effectively to us. We trust the surgery. Some patients at Lisson Grove don't get seen at all and prescriptions are given with minimal information. This could be very dangerous. I work at Plymouth University and we all know of the twenty something story student accommodation block going up in the centre of town. More and more purpose built student accommodation is being built enabling the housing crisis in Plymouth to be alleviated and for families to turn previously student filled areas to residential areas. I understand that the students are largely catered for by Beaumont Villa and Peverell Park but the families that take their place will need local care. We are told that there are many larger surgeries in the area that can accommodate us, but I chose to register myself and my family with Hyde Park because of its smaller more intimate nature. My doctor knows me and my history. In many other local surgeries people don't see the same doctor twice! Bigger is not better. How often have things been amalgamated and the users say "oh, I feel my care is so much more personal"? Finally, I attended one of the drop-in consultations where the process was explained and we were told that we would have to try to give reasons as to why Hyde Park should be allowed to go forward into the procurement process even though there was no reason given as to why it shouldn't. We were told that it wouldn't cost anymore, so why are we being asked to beg for something that should be done as a matter of course? Thank you for your time in reading this response. I truly hope that you make the right decision.
21/09/16	A Lady in her 80s phoned today to leave feedback. She frequents the practice regularly for blood tests and uses a taxi to get there. It's not the nearest practice to her, that would be Mannamead but she has friends registered there and she says she is aware that they are chuck-a-block and have to wait weeks for an appointment. The staff at Hyde Park are very caring and helpful and they always look after their patients. Only this morning she was there and they had 6 people waiting, 2 GPs running surgeries and a phlebotomist and they were doing their upmost to provide an efficient and caring service. It would be devastating if Hyde Park was closed.

23/09/16	Lady phoned in to leave feedback after hearing about the potential closure whilst in hospital. She has been registered with the practice, along with her sons for over 30 years and was horrified to learn it may close. She does not want to register with any other surgery and certainly not the ones suggested as she knows getting an appointment at those surgeries is almost impossible. Her GP at Hyde Park knows her and her family well, she is always able to see the same GP and appointments are easily available on the same day. Continuity of care is really important to her and Hyde Park Surgery provides this.
23/09/16	I am writing to offer my support to the growing concern of the possible closure of Hyde Park Surgery I worked as a practice nurse for (**GP Name redacted**) and his team for several years and had the opportunity to experience first-hand the benefits of offering holistic and consistent care to patients. Not only was I able to maintain an effective patient/nurse relationship I witnessed the obvious relief from patients that they were able to access care from the same Dr/Nurse at a time when a lot of them were chronically unwell and needing medical/nursing care on a regular basis. Patients felt valued, listened to and unrushed which is no easy task when allotted appointment times were being kept. This is certainly in contrast to a number of other larger practices that I worked in where this consistency and nurturing environment was not offered which led to very unsettled patients and staff, leading to an increased number of appointments needing to be allocated to patients. Patients find it very frustrating having to repeat their medical history and what is going on for them at every visit to their Dr because they see a different one every time. This leads to lack of compliance and a breakdown in trust. The importance of the Francis Report which highlighted I quote 'many examples of appalling care is not the experience of healthcare to the vast majority of patients and their families.' I firmly uphold my opinion that Hyde Park offers high quality, effective, evidence based and holistic care to their patients and it will be a very sad day if surgeries like this one are closed. I would like to highlight the 6 Cs: Care, Compassion, Competence, Communication, Courage and Commitment which should be integral to the care of patients. When decisions are being made about closing GP practices and amalgamating them into larger ones or re-housing patients into current ones I urge you to take these into account. The value of small practices should not be underestimated and I for one would like to offer my support in the fight to keep Hyde Park Surgery open.
23/09/16	Following on previous correspondence and meetings at Hyde park surgery, this is just to reiterate my strong feelings about the devious ways of NHS England and all the wrong information that they have circulated. Statistics can be manipulated in a wonderful way. I wish to state that I am very much against the closure of such a wonderful practice and the great treatment given by (**GP Name redacted**), the other available doctors, the staff. This is always very evident in a small family practice where each patient is treated as an individual with respect, courtesy and care. Knowing a lot of friends and neighbours who are listed in the so called multi practices it would appear that a week or more can be the waiting period to have an appointment and each time a different Dr can be seen so it is obvious that a patient can be seen by various doctors who are not au fait with the patient.

	At Hyde Park, it is always possible to see a doctor, if necessary, on the same day and see a doctor who is known to you and who knows you well, All range of treatment and services are available, from minor ops, flu jabs, inoculations, health care, ante natal care screening and childcare, pre conceptual advice, family planning ear syringing, eggs, cervical smears phlebotomist, travel vacs removal of sutures, dressings. Chronic disease management, health checks, learning disability checks, midwifery clinic, smoking cessation clinic. Etc. This is just a small list of what is available at Hyde Park. I did ask the rep from NHS England what else the multi practices could offer, but as yet I have not had an answer. Any other, x Ray's, ultrasound etc is available at one practice to my knowledge, but from my point of view I would prefer to go to the hospital where the radiographers and technicians are highly trained, and not just practice nurses I know at the end of this month you will be collating all information to write up your recommendations about the closures, but I would like you to know that I for one would wish that (**GP Name redacted**) and Hyde Park surgery continues as is and that we can continue to have the excellent care that we have always had. Julia Cory head of primary care, who I believe is on holiday states that small practices are finding it difficult to recruit GPs and offer the extended services and opening times that are possible when working on a larger scale. GP care is the cornerstone of the NHS so we wish to make it as good as possible. Lot of rubbish. We have all this already at Hyde Park, but if GPs are so hard to find, then how are the other practices going to cope when suddenly they have a large amount of extra people signing up. Methinks A and E will be getting busier and busier and then they will have problems.
24/09/16	We were appalled to learn of the possible closure of Hyde Park Surgery, my husband 86 and myself 77 have had excellent care. No problem with appointments with a wide range of services available. There are 2900 patients far more than Mount Gould surgeries which are not under threat of closure both nurse and GP clinics are fully staffed. In contrast to Mount Gould and Ernesettle clinics which struggle to cover these clinics the staff at Hyde Park are confident that they can make the surgery a going concern and the patients are confident this is so. There is no guarantee that if the worst happens we will be accepted by a nearby surgery. At our age we do not want to travel miles to see a doctor when we are ill.
26/09/16	I have been a patient at Hyde Park Surgery since it opened 25 years or more ago and whilst I moved away for a few years during that time, this was owing to being relocated in the Plympton area. When 2 years later I moved back to the city I registered at my local large practice. Sadly I found the service to be impersonal and care-less, so much so I contacted Hyde Park and despite being slightly out of area I begged them to take me back as a patient. I was very pleased when they said yes. I am always recommending Hyde Park Surgery to people when I hear how unhappy they are with their larger and impersonal practices. I can always get an appointment within the week, it's very rare I would have to wait over a week for an appointment and whilst I may have to call again to get through, I do not have to spend hours on the phone waiting for my call to be answered. They have also responded to patient need and provide an evening surgery. All the staff are welcoming and friendly and no matter which GP I see I know that they genuinely care about me and my wider circumstances; including my past experiences, as well as the present. I am currently being supported by one of the GPs concerning the possibility of my son having mild Asperger's. The support from my GP, from a simple phone back service call to bringing my son in for his appointment has been amazingly sensitive and caring, offering real genuine care, emotionally in that moment and practical in terms of what is available within Plymouth and what my next steps might be. This represents to me a surgery that provides real genuine, sincere care. I was also extremely impressed when I brought my son in for his appointment and the GP spent the whole consultation engaging with him rather than through me and even though I was present I didn't feel ignored as the parent. That is what being a professional is to me, the skill to focus on the child who is the patient, making him feel valued but not ignoring the parents role either.

	One of the other GPs recently in the past 6 months went above and beyond to help with another health concern my son was experiencing and as a result I am left knowing that they care about us. I have never once felt the receptionist staff have asked more than I want to share and in fact I wonder if they might be invited to roll out their skills to GP surgeries across Plymouth, as I am well aware that this is an issue at other practices!! Please do not close this surgery, as if you do you are taking away 'my choice' to be part of a smaller practice that genuinely and professionally care about me and my family.

ST BARNABAS SURGERY

24/08/16	We have been at the surgery for over 30 years and do not want it to close. This is the only surgery we have known and will have to go somewhere else. We are concerned about the distance we will have to travel having lived so close to St Barnabas Surgery.
25/08/16	As a small practice they know you, and you know them. This makes for a trusting and pleasant healthcare experience. Over the years they have helped me in many ways, not just with personal health, arranging hospital procedures and so on, but also with bespoke examinations for work, travel advice and inoculations, smoking services, health checks and so on. I have always found them helpful, available (within reasonable constraints), professional and effective.
25/08/16	My wife had problems with a nearby large surgery, to the extent that dealing with them made her anxious and tearful and she avoided using them. She was given the impression that she couldn't move to St Barnabas. When she found that she could she moved herself and my daughter immediately, and has had no problems since.

Engagement Process

Background

Healthwatch Plymouth were approached by NHS England South (South West) lead for Communications and Engagement in early June 2016 to discuss a possible engagement process around future commissioning intentions for 6 existing GP Surgeries (Mount Gould, Ernesettle, Trelawny, Hyde Park, St Barnabas and Cumberland) in Plymouth as well as an additional new GP service being considered for the Barne Barton area of the city. A recent 12 month interim contract had been awarded to Access Health Care to run Mount Gould, Ernesettle, Trelawny, Hyde Park, St Barnabas and Cumberland surgeries. The interim contract award was due to GP retirement at one practice and notice from current providers of the other practices to withdraw from their contracts from 1 April 2016. The commissioning intentions were to seek a new provider for Mount Gould, Ernesettle and Trelawny and not to recommission services at Hyde Park, St Barnabas and Cumberland surgeries. These intentions were made public by NHS England in letters to patients of the affected practices. In addition a new GP service was being considered for the Barne Barton area of Plymouth.

Healthwatch Plymouth advised on ways to engage with patients meaningfully and in a timely way. We discussed that patients should be given the opportunity to ask questions about the commissioning process, as well as have their experiences and concerns listened to. We advised that the communication plan should include a media release and individual patient letters for the surgeries involved. We were also happy to help facilitate any engagement where possible, but were clear that we would not lead the engagement activity (due to staff capacity), which was to be organised and run by NHS England.

An initial engagement plan was formulated by NHS England that saw visits to Hyde Park, St Barnabas and Cumberland Surgeries on the 25 August 2016 followed by visits to Ernesettle, Mount Gould and Trelawny surgeries on 8 September 2016. The plan also included a media release and individual patient letters for Hyde Park, St Barnabas and Cumberland surgeries. Healthwatch Plymouth had visibility of the plan and finalised documents on 17 August 2016, after patient letters had been finalised and forwarded to the company contracted to print and dispatch them.

On Friday 19 August 2016, we were advised by telephone that there had been an internal delay the in posting out of patient letters, but that this was expected to be complete on Monday 22 August 2016. We were also advised that the media release had been sent to Radio Plymouth and the Plymouth Evening Herald. Both organisations had been requested to hold back on the media release until Tuesday 23 August 2016 to allow for delivery of letters to individual patients to be completed.

On Tuesday 23 2016 August Healthwatch sought confirmation that the patient letters had been posted and also asked whether additional engagement events were planned given the delay in posting. Reassurance was given that additional engagement opportunities would be available and we received an updated plan late on Friday 26 August 2016. Due to the Bank Holiday, we were unable to respond to this plan until the morning of the first of the round 2 events. This meant that Healthwatch were not in a position to support the event at St Barnabas on 30 August 2016.

We also suggested that in view of the delay in notifying patients of the first event, that the event should be rearranged for a later date to allow patients more time to plan attendance.

HEATHWATCH COMMENT:

Delays in issuing patient letters as well as a media release made public prior to patients being informed, led to a hectic and disjointed first set of engagement events at Hyde Park, St Barnabas and Cumberland surgeries. In some cases patient letters were received on the day of these first events leaving little chance for patients to make arrangements to attend. The timing of the first engagement event is also questionable falling towards the end of August (summer holiday period) and two days before the bank holiday weekend; times that traditionally we would expect to see a lower level of engagement from the public.

It was also clear from the patient letters that some information was not as up to date as it should

have been and could be considered misleading. Accurate statistical information (with a date) should also have been used to avoid further confusion.

Additionally, patients who attended for the first engagement session on the 25 August 2016 were under the impression that it was a meeting to discuss the future of the surgery; not a one to one session to complete a questionnaire; it became clear from the first drop-in at Hyde Park that staff attending did not have the capacity to provide a one to one service for this and patients were left to complete the form on their own. The confusion at the start of the engagement could have been avoided by:

- Being clear in the patient letters about the type of engagement being run
- Re-iterate how the engagement was being run by addressing those patients in attendance at the start of the event

Although NHS England responded to the delay in posting of patient letters, by arranging additional engagement opportunities at all surgeries, the timing of the second round of engagement straight after the bank holiday weekend is also concerning especially as communication of these additional dates to patients was only made available via a notice in the affected surgery's waiting room. These additional dates should have been better considered allowing for patients to be informed about them via letter in a more reasonable timeframe. It was felt necessary to invite patients individually to the first session; we would have anticipated that the same process would have been followed. Tight deadlines could have been considered earlier and a delay to the process implemented to allow for additional communication and engagement (as indeed it was in mid-September).

When arranging multiple events on the same day, timings should have taken into account Surgery lunch hours. Sessions commencing at 1200 were effectively restricted to 60 minutes vice the planned 90 minutes due to lunch hours commencing at 1300. This was even more acutely important given the short notice to patients about initial and subsequent opportunities to engage.

The engagement process would have benefitted from having an opportunity for a Q&A session at each surgery allowing a wider range of patient concerns to be captured and addressed that the form used at other events didn't allow for.

Healthwatch Plymouth issued a media statement around '*our advice to NHS England on how best to engage with patients*' and '*our disappointment that patients were not invited individually to the additional sessions*'. Members of the public have contacted us to express their disappointment that engagement did not feel meaningful, many feeling a decision had already been made. The issue of a press release at this stage was to confirm our position, and to encourage patients to continue to share their views with Healthwatch Plymouth.

Healthwatch Plymouth is also concerned regarding the accuracy of data used during this process. Information provided around patient list size to the Task and Finish Group, data included in letters to patients and subsequent requests for information to NHS England by Healthwatch Plymouth, show that data provided varies in age from 30/06/2014 to 30/06/2016. This causes us concern that decisions can potentially be made using dated information. We appreciate that there can be a time delay in receiving up to date information, however our records indicate that there is an inconsistency with patient list size information.

Healthwatch Plymouth assisted with recording of the views shared at many of the engagement sessions. We did not retain this information and provided it immediately to NHS England. Although our recommendations address the planning and scope of wider engagement, we feel it important to note that during the sessions, NHS England staff were open with those spoken to about the uncertainty of the procurement process at this stage, and encouraged patients to share their views directly with them or through Healthwatch Plymouth. NHS England offered patients the opportunity to supply contact information to be kept up to date with key developments.

Recommendations:

1. Further engagement activity with patients and agencies is conducted to fully inform the Equality Impact Assessment for each Surgery.
2. Future engagement activity needs to be robust. Consider issues that could significantly pose challenges in its delivery. Challenges include delay in letters, notification of additional engagement opportunities and patient expectations of engagement.
3. Patient letters should contain the most up to date information to avoid being considered as misleading.
4. Letters should be clear as to what the purpose of the engagement is for so that members of the public have an unambiguous understanding of the event.
5. Data used is consistent during the process, data provided to Healthwatch at the beginning of the process shows list size information from 2014, but is quoted as being from 2016. This has the potential to be considered misleading.

This page is intentionally left blank