

Care Quality Commission

Inspection Evidence Table

The Manor Park Practice (1-2080560501)

Inspection date: 2 September 2019

Date of data download: 21 August 2019

Overall rating: Good

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

Effective

Rating: Good

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence: Monthly clinical meetings took place where best practice guidelines including NICE guidelines were discussed. Care and care plans were appropriate for all population groups and long term conditions; including for older people, palliative care, learning disabilities, cancer, asthma, diabetes, and Chronic Obstructive Pulmonary Disease (COPD). The practice held monthly clinical educational meetings. Recent examples of topics discussed	

included hypertension and diabetes.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) <small>(NHSBSA)</small>	0.05	0.32	0.75	Significant Variation (positive)

Any additional evidence or comments

Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) was below local and national averages which is a positive performance indicator.

Families, children and young people Population group rating: Good

Findings

- NHS England data for the period 1 April 2018 to 31 March 2019 indicated childhood immunisation uptake rates were significantly below the World Health Organisation (WHO) targets. The practice was aware of this data and thought it was potentially inaccurate due to a system / data problem, staff showed us unverified data held on the practice system that indicated uptake for childhood immunisations was improving quarter to quarter over the last three quarters and was 93% at 1 April 2019. Staff told us they were trying to establish the reasons for the discrepancy in the data. For children that did not attend their immunisation appointment the practice sent a text message reminder to their parent or guardian followed by a telephone discussion to encourage attendance. Where children did not attend for their immunisations those cases were coded as “child not brought” in accordance with local safeguarding arrangements, GP consideration was triggered and discussion with a Health Visitor or other allied health and social care professional where appropriate.
- The practice had implemented a specific protocol to increase child immunisations uptake that included patients and guardian’s engagement and education by proactively communicating with patients in their first language, including Bengali that was widely spoken by staff and in the local community. The practice had a spreadsheet showing child immunisations for every child under five years of age with manual entries and highlighting specific gaps for follow up; for example, for children that had received some immunisations abroad.
- The practice had arrangements for following up failed attendance of children’s appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception and the practice provided Chlamydia and HIV screening in house.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	21	65	32.3%	Below 80% uptake
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	31	69	44.9%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	31	69	44.9%	Below 80% uptake
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	32	69	46.4%	Below 80% uptake

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Working age people (including those recently retired and students)

Population group rating: Good

Findings
<ul style="list-style-type: none"> The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who	65.6%	N/A	N/A	Below 70% uptake

were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	57.1%	55.0%	69.9%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	39.1%	45.1%	54.4%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	80.0%	80.4%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	28.6%	44.3%	51.9%	No statistical variation

Any additional evidence or comments

Data showed the practice had a significantly negative performance data variation for:

- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018). The practice was aware of this and in response had:
- Designated staff members to focus on improving uptake, including a Bengali speaking staff member to call patients in person.
- Undertaken cervical screening audits, where the first cycle identified 16% inadequate samples, the practice held educational sessions for sample takers then re-audited which showed the inadequate sample rate had fallen to 4%. The latest unverified data held on the practice system indicated performance was improving and was currently 78%.

Data showed the practice had below average performance for:

- The number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE). The practice was aware of this and in response had:
- Reviewed all new diagnosis cancer cases for the previous two years including those diagnosed in secondary care and looked for learning points;
- Held cancer educational sessions in house; and
- Monitored rates of cancer detection as a result of referrals made by the practice. The latest unverified data held on the practice system indicated performance was improving and the number of new cancer cases treated detection rate which resulted from a two week wait referrals made by the practice was 40%.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement

activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	524.0	510.1	537.5
Overall QOF score (as a percentage of maximum)	93.7%	91.2%	96.2%
Overall QOF exception reporting (all domains)	2.8%	5.1%	5.8%

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

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

Audit area	Impact
To ensure patients patient's prescribed levothyroxine have appropriate blood tests monitoring.	In the first cycle 87% of all patients prescribed levothyroxine were receiving appropriate blood tests monitoring. The clinical team met to discuss the results in light of best practice guidelines, and in the second audit cycle the percentage of all patients prescribed levothyroxine had increased to 91%.
To ensure appropriate checks for babies six to eight weeks old.	In the first cycle 77% of all babies six to eight weeks old had received appropriate checks. Staff met to discuss ways to improve and staff called parents and guardians directly to encourage them to bring the babies in for checks. In the second audit cycle the percentage of babies six to eight weeks old that had received appropriate checks had increased to 91%.
Any additional evidence or comments	
The practice had undertaken fourteen audits within the last two years, including audits on deaths, cancer care, and medicines prescribing such as antibiotics. Eight of these audits were two cycle clinical audits.	

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y

The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, pharmacists.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw staff were able to manage data and by using internal systems effectively in accordance with their roles. For example, referrals to other services were prompt, well documented and followed up.</p> <p>Staff were appropriately trained in line with duties. The practice had a training policy but no method to check it was implemented. However, management staff completed a training matrix on the day of our inspection and we checked a sample of six staff files where the only gap was a healthcare assistant that had not received infection control update training within the last year but was trained in June 2018.</p>	

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) <small>(QOF)</small>	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Monthly multidisciplinary meetings were held as well as additional communications as needed for palliative care, MH, DN vulnerable patients.</p> <p>Additional multidisciplinary meetings were held quarterly, specifically for looked after children and</p>	

included attendance from the Child Nurse and Health Visitor.

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was varied health promotion in the reception area including relating to cancer screening, immunisations and common ailments.</p> <p>Patients feedback and care plans indicated staff encouraged and educated patients appropriately to help patients live healthier lives.</p> <p>Evidence showed the practice was proactive in helping smokers such as referring for health promotion dietary and exercise advice. Unverified data held on the practice system showed 89% of patients that smoked had received smoking cessation advice.</p>	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	97.5%	96.5%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.2% (2)	0.7%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y

Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y
Explanation of any answers and additional evidence: We checked records for cervical screening and immunisations and saw evidence patient's consent was sought and recorded.	

Well-led

Rating: Good

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: The two GP partners provided clinical leadership. One of the GP partners was significantly involved in day to day management due to interim management arrangements where the practice manager worked two days per week, the assistant practice manager five mornings per week, and there was a trainee practice manager working with a long term comprehensive induction and handover plan in place. There was an organisational structure with delegated leads in areas such as GP lead for Safeguarding adults and children and overall for Health and Safety; Management leads for complaints, fire safety and carers; and a Practice Nurse lead for infection prevention and control. Our inspection made random checks in all these areas and all were managed effectively. Leaders and managers had identified opportunities, risks and areas of underperformance and had an action plan they were implementing to address clinical and other priorities. For example, the practice was improving cancer identification and patient care, child immunisations uptake, auditing reasons for patient's deaths and taking steps to reduce appointments wasted due to DNAs (where a patient Did Not Attend). Staff and patients told us leaders and managers and staff at all levels were compassionate and inclusive.	

Vision and strategy

The practice had a vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
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The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Practice staff understood the vision, priorities and values of the practice.</p> <p>The practice strategy was not formalised but included a plan to move into a new purpose-built premise in conjunction with a neighbouring GP practice, by approximately the end of 2021. Staff told us the ground works for the building had started.</p>	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff had access to and whistleblowing policy and told us there was an open working culture.</p> <p>The practice staff team was cohesive and motivated. Staff told us there was an open and accessible leadership and management team that were focused on providing high and improving standards.</p> <p>Complaints and significant events evidence showed the practice was open and honest with patients and apologised to patients, where appropriate.</p>	

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

Source	Feedback
A range of non-clinical and clinical staff.	Staff felt it was a friendly, professional and happy place to work. The receptionists informed us that the practice manager and GPs were very supportive.

Open door policy.	Encouraged openness and support for staff across all roles to approach and discuss any issues with leaders and managers.
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Governance arrangements

There were clear responsibilities and roles and systems of accountability to support good governance and management were generally in place.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<p>Some systems or structures to ensure good governance needed establishing, reviewing or embedding, including to ensure sufficient responsible managers oversight.</p> <p>For example, monthly management meetings had not occurred for seven months and the minutes had no framework to ensure actions agreed or follow up. There was insufficient management oversight of staff training plans. Recruitment and other HR arrangements were generally effective but there were no contracts or working agreements for locum GP and nursing staff, or references for a member of locum nursing staff. Emergency medicines and equipment were fit for use, but management staff could not find the records of checks on emergency use oxygen and we found staff were recording this information in a book intended for recording temperatures of the medicine's refrigerator. The practice had implemented a plan to reduce where patients did not attend for appointments but not all managers were able to access it.</p> <p>Regular clinical, whole staff, PPG (Patient Participation Group), and multidisciplinary meetings took place and were effective.</p> <p>Systems to ensure patients registration and summarising of records, documents management, and urgent and non-urgent referrals were appropriate.</p> <p>Policies and procedure were accessible to all staff via a shared desktop folder.</p> <p>Arrangements for seeking and obtaining patients consent for care and treatment were effective.</p>	

Managing risks, issues and performance

There were processes for managing risks, issues and performance but some needed reviewing to ensure they would remain effective.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y

Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Assurance systems were generally in place and effective, but some needed to be reviewed. For example, systems for safety alerts were effective in the 12 months prior to our inspection and we checked several examples; however, there was a safety alert issued more than 12 months ago that that had not been followed up which related to the defibrillator which is an essential item of emergency equipment. Staff checked and confirmed the defibrillator as fit for use on the day of our inspection.</p> <p>There was a delegated person to manage uncollected prescriptions. We did not find any high or moderate risk prescriptions uncollected or any older than two months; however, management staff had not identified that prescriptions were being destroyed and there was no audit trail for the destroyed prescriptions.</p> <p>CCTV was installed inside the building such as the reception area but there was no signage inside the building to let patients know this was the case. Staff placed signage up on the day of our inspection, but it was not sufficiently visible / conspicuous. There was no signage or other means to ensure patients privacy at the reception desk which needed to be considered because seating was near the counter and we observed patients standing in close proximity, and on some occasions next to each other which meant there was a risk patient's private conversation might be overheard. Staff were aware they could offer a private space for patients to discuss issues where needed.</p> <p>The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Staff were consistent and proactive in helping patients to live healthier lives.</p> <p>Arrangements for significant events to improve safety in the practice were effective and appropriate documentation was in place. We noted there had been 11 significant events the practice identified in the year prior to our inspection, we checked several and all were promptly identified and well managed including positive examples to reaffirm and embed good practice.</p> <p>Staff were appropriately trained in safeguarding at a level appropriate to their role. There were effective processes for safeguarding including registers and alerts where needed for protected and vulnerable patients.</p> <p>Patients including those prescribed high risk medicines and patients with long term conditions were appropriately clinically monitored and engaged in their care.</p> <p>The practice had undertaken, and analysed Friends and Family test surveys mostly via patient's text message responses, and these results aligned with the GP Patient survey results that indicated patients were satisfied. We collected 36 CQC patient comment cards where patient's feedback indicated the practice was performing in an efficient and caring way, and that staff were kind and professional.</p> <p>Health and safety risk assessments and remedial actions were undertaken to improve safety including for fire, infection control and premises and an effective major incident plan was in place.</p>	

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
<p>Clinician's had access to and discussed current legislation, standards and evidence-based guidance to inform patient's care and treatment.</p> <p>The practice had used data such as clinical performance and patient satisfaction measures data to monitor and improve its performance, including improving patients telephone access by installing a new telephone system.</p> <p>The practice had an action plan that included areas the CQC said it should improve at its previous inspection to ensure carers are identified on the clinical system and information, advice and support is available to carers.</p> <p>Staff performance appraisals were undertaken annually but there was no method to ensure continuous professional development opportunities were revisited and followed through.</p>	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<p>Complaints were properly responded to, investigated and acted upon to improve the service and we found evidence of the duty of candour in complaints and significant events management.</p> <p>A partner GP was co-leading the newly formed Primary Care Network (PCN) group of practices and co-ordinating actions to secure additional pharmacist and social care navigator staffing provision.</p> <p>The practice was aware of and provided its services in line with local needs and in line with best practice guidelines.</p>	

Staff went on social events and outings together and told their ideas were listened to, and that it was a cohesive and caring staff team that felt motivated and supported.

Feedback from Patient Participation Group.

Feedback

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

The PPG had submitted proposals to improve that were implemented including improvements to the telephone system.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
The practice told us about and demonstrated participation in several innovations to improve and sustain high quality care. For example, dedicated child protection meetings, ongoing participation in the national cancer diagnosis audit program to continuously improve and contribute to this local and national priority, identifying frequently attending patients at both out of hours and accident and emergency services and calling these patients in for a GP review appointment, and monthly psychologist clinics open to all patients within the CCG.	

Examples of continuous learning and improvement

A broad and embedded range of continuous clinical improvement activity such as clinical audits.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

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

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

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

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

Glossary of terms used in the data.

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