

Care Quality Commission

Inspection Evidence Table

Lanark Medical Centre Ground Floor (1-6989677395)

Inspection date: 15 & 17 September 2021

Date of data download: 29 September 2021

Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20

Effective

Rating: Good

At the January 2020 inspection the practice was rated as requires improvement for providing effective services because:

- Childhood immunisations and cervical screening uptake were below national averages.

At this inspection we found that there had been an improvement in the childhood immunisation rates which were just below the required target. There had also been a slight improvement in the cervical screening uptake.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At the January 2020 inspection we reviewed a selection of clinical records we found that patient care and treatment was delivered in line with current evidence-based guidance. However, on the day of the inspection the lead GP could not demonstrate a formal system to receive or share updated guidance with clinical staff. At this inspection we found that the Practice received updates to the latest guidelines via the NICE newsletter, CCG bulletin, and the Central London Healthcare (CLH) bulletin, as well as from other sources such as the Practice Index newsletter. There is a standard agenda item on the Practice meeting that is used to disseminate and discuss new and updated guidelines. 	

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. The practice carried out structured annual medicines reviews for older patients. Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. Health checks, including frailty assessments, were offered to patients over 75 years of age. Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Good

Findings
<ul style="list-style-type: none"> Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions. The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. However on the day of inspection we looked at seven diabetes records and found that not all had been coded properly. Soon after the inspection the practice reviewed these records

and found that some of these patients were no longer diabetic but the codes had not been updated, the remaining patients were invited in for either a blood test or referral to an education programme. The Practice altered the procedure so that in the future any patients pre diabetic or diagnosed with diabetes would be invited for a review with the clinician. Patients that did not attend the appointment or failed to respond would receive a letter detailing the reason and importance of the appointment.

- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	71.0%	76.9%	76.6%	No statistical variation
PCA* rate (number of PCAs).	1.2% (2)	7.6%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	80.0%	90.1%	89.4%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	9.4%	12.7%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	84.0%	83.4%	82.0%	No statistical variation
PCA* rate (number of PCAs).	1.6% (2)	4.2%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	78.8%	66.7%	66.9%	Tending towards variation (positive)
PCA rate (number of PCAs).	3.8% (8)	12.9%	15.3%	N/A

The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	75.0%	73.7%	72.4%	No statistical variation
PCA rate (number of PCAs).	2.3% (7)	6.3%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) <small>(QOF)</small>	89.7%	90.5%	91.8%	No statistical variation
PCA rate (number of PCAs).	3.3% (1)	5.6%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	84.7%	76.4%	75.9%	No statistical variation
PCA rate (number of PCAs).	0.9% (2)	8.7%	10.4%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Families, children and young people

Population group rating: Good

Findings

- The practice has not met the minimum 90% for four of five childhood immunisation uptake indicators. However, the uptake was an improvement on the January 2020 inspection rate.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- 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.
- 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) (01/04/2019 to 31/03/2020) (NHS England)	33	35	94.3%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	40	47	85.1%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	42	47	89.4%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	40	47	85.1%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	25	36	69.4%	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>

Any additional evidence or comments

The practice had a reminder and recall system and contacted parents or guardians of children who had failed to attend. The practice proactively facilitated access to appointments at local GP hubs which had late evening and weekend appointments.

We saw that there had been some improvement in uptake for two-year-olds when compared to the January 2020 inspection. We found:

- The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) was 74% and was now 85%.
- 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) was 82% and was now 89% (2019).

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

- The practice achievement for cervical screening was 49% and significantly below the England average of 70% and the national target of 80%.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2021) (Public Health England)	49.6%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	53.3%	62.2%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	35.3%	51.4%	63.8%	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 (01/04/2019 to 31/03/2020) (QoF)	100.0%	93.5%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	25.0%	57.6%	54.2%	No statistical variation

Any additional evidence or comments

- The practice was aware that the achievement for cervical screening was 49% and considerably below the England target of 80%. The practice introduced several measures to try to improve this including; Added additional clinics to provide extra smear clinics. Non-clinical staff had been booked on a cervical screening workshop training designed to help staff explore ways to improve

the number of women booking appointments. Patients were encouraged to access cervical screening appointments at a local GP hub practice in the evenings and at weekends.

- The uptake for patients who participated in the national cancer screening programs for bowel and breast cancer was below national targets. The practice was aware of this and told us they would discuss opportunistically with a patient during a consultation and had posters around the surgery.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- A mental health nurse clinic was held at the practice fortnightly.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Clinical staff had received dementia training.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	81.8%	85.3%	85.4%	No statistical variation
PCA* rate (number of PCAs).	5.7% (2)	10.0%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	100.0%	82.6%	81.4%	Variation (positive)
PCA rate (number of PCAs).	0.0% (0)	5.6%	8.0%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Monitoring care and treatment

The practice had a comprehensive program of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	529.9	533.9
Overall QOF score (as a percentage of maximum)	94.8%	95.5%
Overall QOF PCA reporting (all domains)	6.8%	5.9%

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

The service carried out 4 audits in the last 12 months, one of which was on patients who had been prescribed Quinine. Quinine is generally not recommended for treating idiopathic leg cramps due to the poor benefit-to-risk ratio; therefore, the rationale of this audit is to assess the on-going need for Quinine with a view to stopping this medication where possible.

The aim of this audit is to review all repeat prescriptions for quinine, considering appropriate indication, dose, contraindications, cautions, adverse effects and drug interactions. In addition, the audit provides the opportunity to stop quinine where appropriate to reassess on-going need i.e., trial discontinuation.

In December 2019 thirty-nine patients were identified to be prescribed Quinine:

- 64% were able to manage leg cramps through lifestyle measures alone and agreed for Quinine to be removed from their repeat prescription.
- 36% of patients were kept on quinine but agreed to trial discontinuation every few months (14 patients in total).

In December 2020 there were only 7 patients on Quinine. All 7 patients have a script note added for quinine, advising for trial discontinuation every few months. In July 2021 this was down to 4.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a program of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction program for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:	
The practice had identified core mandatory training for staff which included basic life support, infection prevention and control, fire safety, safeguarding children and adults, mental capacity act, equality and diversity, prevent, chaperone, sepsis, information governance and health and safety. They had also introduced a skills competency and training needs assessment as part of their induction process. All staff had regular appraisals this included internal appraisals for GP's as well as their NHS GP appraisal.	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centered care when they moved between services.	Y

Helping patients to live healthier lives

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

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

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence:	

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. Clinicians had a good understanding of the Mental Capacity Act (MCA) and had received training.
- We saw evidence of signed consent forms for minor surgical procedures and scanned consent forms on patient records.

Well-led

Rating: Good

The practice is rated as Good for providing well-led services because:

At the January 2020 inspection the provider had not ensured that effective systems and processes were in place to ensure good governance in accordance with the fundamental standards of care. In particular;

- Governance systems had failed to identify gaps in relation to safety-netting of urgent two-week wait referrals and cervical cytology, quality improvement, induction and skill competency processes and policies and procedures. At this inspection we found that the provider had implemented improvements in all these areas.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels. Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	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 program, including a succession plan.	Y

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that Prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y

Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice told us that their mission statement was 'To deliver the highest level of medical care to our local populations; deliver health care in a flexible and innovative way to meet patient choice and reflect the changing political and economic circumstances. To ensure patients are always at the 'heart' of everything we do: ensuring patients are treated with dignity, respect, empathy and sympathy.' 	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behavior 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 candor.	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 candor, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y

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

Source	Feedback
Staff Interview	Staff told us that they felt supported by the management who were very approachable.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y

Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At the January 2020 inspection we found gaps in management oversight and some systems and processes were not sufficiently embedded to ensure good governance. For example, there were gaps in quality improvement, which included the absence of a program of clinical audit, no formal system to review and document clinical notes and prescribing of clinical staff and no clear system to receive, disseminate and discuss new and updated evidence-based guidance. In addition, we found gaps in relation to safety-netting of urgent two-week wait referrals and monitoring cervical cytology and the practice's induction processes had failed to appropriately assess the skills competency and training needs of a newly recruited practice nurse. <p>At this inspection we found that the practice had developed a program of quality improvement and had done 8 audits in the last 2 years, carried out reviews of clinical notes and prescribing. They now had a formal system to ensure the dissemination and discussion of new guidance and safety alerts. They had introduced fail safes for cytology and 2 week waits and a skills competency and training needs analysis for newly recruited staff.</p> <ul style="list-style-type: none"> At the January 2020 inspection we found that some practice specific policies including, child and adult safeguarding, infection control and significant events held out of date information and insufficient detail. At this inspection we found that the policies had been reviewed and were up to date and had the appropriate level of detail. 	

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement program in place.	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

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y

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 monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y

Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had an active Patient Participation Group (PPG) who met quarterly. 	

Continuous improvement and innovation

There were 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

Examples of continuous learning and improvement

- The practice had engaged in the Productive General Practice (PGP) Quick Start quality improvement program to review processes and systems and develop internal efficiencies.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

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

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

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

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

Glossary of terms used in the data.

- COPD:** Chronic Obstructive Pulmonary Disease.
- PHE:** Public Health England.
- QOF:** Quality and Outcomes Framework.
- STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- *PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
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- ‰ = per thousand.