

Care Quality Commission

Inspection Evidence Table

The Spalding GP Surgery (RY5Z3)

Inspection date: 14 June 2022

Date of data download: 13 June 2022

Overall rating: Inspected but not rated

We rated the practice as Requires Improvement overall at our inspection in November 2021. At this inspection, we carried out a focused unannounced inspection following concerns raised directly to the CQC. We focused on areas of the domains for Safe, Effective and Well led.

Safe rated

Rating: Inspected but not

We rated the practice as requires improvement for providing safe services in November 2021. At the time of this inspection the practice was continuing to work towards an action plan to meet the requirements of breaches we found during the inspection in November. At this inspection we found that:

- The practice had insufficient assurance around recruitment checks of staff such as vaccinations and Disclosure and Barring service checks.
- The practice had insufficient assurance around training of staff.
- There was not always an effective approach to managing staff absences and at periods there had been no clinicians on site.
- The practice did not have an effective system to learn and make improvements when things went wrong. Significant events were not always investigated, and learning was not always implemented.

Safety systems and processes

The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Partial ¹

Safeguarding	Y/N/Partial
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes ²
Disclosure and Barring Service (DBS) checks were undertaken where required.	No ³
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes ⁴
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> ¹We viewed safeguarding training for new starters and found that training had been completed to level one and not to level two as set out in the intercollegiate guidance. Following the inspection we were told by the provider that new starters were booked onto courses to complete safeguarding level two training. ²The practice had registers of vulnerable patients. We reviewed a sample of records and found safeguarding concerns had been referred to the safeguarding team and documented correctly. ³We viewed files for a locum staff member and found there was not a DBS check in place. A DBS check identifies whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable are required for all clinical staff and some non-clinical staff. We were told that the practice did have a service level agreement in place with the locum agency. ⁴We were told that the practice met with other health and social care professionals on a six weekly basis to discuss adults and children at risk of significant harm. The practice had a safeguarding lead and a safeguarding hub within the Lincolnshire Community Health Services trust for guidance and information. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	No ¹
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	No ²
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> ¹Recruitment files were not stored on site. The practice requested information from the providers recruitment team. We found that not all recruitment checks were carried out. For example, a locum staff member did not have evidence of a DBS certificate or vaccinations. There was also gaps in staff members evidence of qualifications. ²We reviewed four staff member files and found three did not have their vaccination status recorded in line with current UK Health and Security Agency guidance. 	

Risks to patients

There were gaps in systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
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There was an effective approach to managing staff absences and busy periods.	Partial ¹
There was an effective induction system for temporary staff tailored to their role.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Partial ²
There were enough staff to provide appointments and prevent staff from working excessive hours	Partial ³
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • ¹Since our previous inspection in November the practice had appointed two locum GPs. A locum GP was available remotely to work through a backlog of clinical correspondence that had accumulated during January to May 2022. A second locum GP worked remotely two days per week and three days on site to see patients face to face and telephone consultations. There was an employed GP who was present at the practice to see patients face to face and telephone appointments three days per week and remotely one day per week. We were told the workload at the practice had been excessive and unmanageable in previous months and since the appointment of the locums in May 2022 the workload had become more manageable and access for patients had improved. The practice leadership articulated their difficulties in finding GPs to cover periods of absences and confirmed there were dates in Spring 2022 when there was no GP at the practice. • ²There was a team of newly appointed reception staff and the practice were actively recruiting for further posts. On the day of our inspection we found that staff did not always ascertain if patients needs were urgent or not. For example, we found patients calling to book an appointment were not asked for symptoms but were signposted to book online via an online application (app). The practice told us the app did include further signposting for patients who were acutely unwell. • ³The practice was actively recruiting for an advanced nurse practitioner at our inspection in November 2021 and was still recruiting at our inspection in June 2022. Prior to May 2022 we were told of the difficulties of being able to offer appointments for patients with long term conditions due to a reduced nursing team. At the time of our inspection the practice had actively invited patients with long term conditions to book with the GPs one day per week. The practice plan was to recruit an ANP to see patients with long term conditions. • ⁴Staff we spoke to told us they had worked excessive hours for periods of time due to a reduction of staff. Staff were hopeful with the increase in GPs and ongoing recruitment that this would no longer be necessary. 	

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes

Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial ¹
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial ²
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> ¹We were told that the practice had a backlog of pathology reports from March and April 2022 due to a shortage of clinical staff. The practice had worked hard to address the backlog and we were told at the time of our inspection the practice were up to date with pathology reports. ²Evidence we reviewed the following day after our onsite inspection found there were a total of 457 open tasks. Tasks are used as a form of communication for example, tasks can include reminders to individual team members, reminders to call patients back or to follow up blood tests or referrals. Of the 457 tasks 233 tasks were assigned to reception, 11 to doctors' groups, 34 to medical secretaries, four to nurses and one to pharmacist. Of the tasks assigned to individual staff no individual had more than 15 tasks pending. Out of 457 tasks 235 tasks were shown as not started and 23 dated prior to June. There was no urgent tasks awaiting. Evidence we reviewed the following day after our onsite inspection found there were no scanned documents awaiting processing. We were told by staff there had previously been a backlog of documents awaiting scanning, but the practice were now up to date. 	

Track record on safety and lessons learned and improvements made

The practice did not have a system to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Partial
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	45
Number of events that required action:	17
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Staff were unsure of who to report incidents to but knew how to raise a concern, incident and near misses onto the digital system. Since our inspection in November 2021 the practice had implemented a procedure to raise concerns on a digital system. On the day of our inspection the practice had 17 significant events that had been raised during the period of 31 December 2021 to June 2022 that had not been 	

actioned. Nine were awaiting to be reviewed and actioned. Eight had been reviewed but were awaiting further actions. We were told that the delay in reviewing and actioning significant events was due to staffing shortages and inexperienced team members using the system.

- Of the nine significant events that had not been reviewed or actioned, the incidents raised included blood results not actioned upon and three days where there was no GP on site. The provider had not recorded any investigations or lessons learned.
- Of the eight significant events that had been reviewed but not actioned there was incidents raised that included safeguarding concerns and blood test results not actioned. The provider had not recorded any investigations or lessons learned. We were told by management that some significant events did not include all the details and therefore were unable to be thoroughly investigated. This was raised during a staff meeting.
- 28 significant events were recorded as fully approved however ten did not have any evidence of learning or dissemination of information.

Example(s) of significant events recorded and actions by the practice.

Event	Specific action taken
Patient arrived at the practice but was booked for a telephone appointment. Patient was refused to be seen face to face due to Covid-19.	No actions taken
No GP on site	No actions taken

Effective Rated

Rating: Inspected but not

We rated the practice as requires improvement for providing effective care in November 2021. At the time of this inspection, the practice was continuing to work towards an action plan to meet the requirements of breaches we found during the inspection in November. At this inspection we found that:

- Patients needs were assessed and care and treatment was delivered.
- The practice had worked hard to address a backlog of patients whom were not able to access care for long term conditions due to a shortage of clinical staff in the Spring of 2022.
- The practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes

Management of people with long term conditions

Findings

- The practice had worked hard in the weeks prior to our inspection to review patients that were not seen during previous months due to a shortage of staff. At the time of our inspection the practice had a locum GP working remotely to work through a backlog of patients who were due long-term

condition reviews. At the time of our inspection the practice had invited all patients and were confident that the backlog would not occur in future due to the increase in GPs.

- The salaried GP confirmed that the practice would run regular searches on the system and now had dedicated time to complete this.
- 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 GPs worked with other health and care professionals to deliver a coordinated package of care.
- Evidence we reviewed demonstrated the practice had an effective system for supporting patients with long-term conditions. For example, searches of the clinical system found patients with chronic kidney disease and hyperthyroidism were monitored with appropriate reviews.
- The practice did not have an advanced nurse practitioner or nurses that were trained to review patients with long-term conditions. However, we were told nurses at the practice had applied for long term conditions training in diabetes and asthma. The practice GPs were responsible for reviews of patients with long-term conditions. There was a dedicated Wednesday afternoon for patients to attend.

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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	33	37	89.2%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	24	29	82.8%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	24	29	82.8%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	24	29	82.8%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR)	20	33	60.6%	Below 80% uptake

(01/04/2020 to 31/03/2021) (NHS England and Improvement)				
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Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Any additional evidence or comments

We found that patients were booked at the appropriate times for immunisations. Immunisations were booked in with the practice nurse.

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.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

Any additional evidence or comments

The practice held a quality and assurance meeting once per month via Microsoft teams which included managers and clinicians across the Lincolnshire Community Health Services Trust. Audits were completed by the salaried GP who told us they had completed audits recently for antibiotics and two week referrals.

Effective staffing

The practice was unable 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.	Partial
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Partial
There was an induction programme for new staff.	Partial
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.	Yes

There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> On the day of inspection, we saw examples where staff were not providing patients with the appropriate support and guidance in terms of registering at the practice and appointment bookings. We were told by the provider on the day of our inspection that our concerns would be addressed. The practice team had several newly appointed team members who were new to primary care, the practice did not have a local induction procedure and we found inconsistencies with information given to patients. The practice had a programme of learning development however, we found that not all staff had completed the programme. The provider had a corporate induction for all staff members which included mandatory training and information. However, the induction was not tailored to specific roles. For example, we were not provided with information on how reception staff were trained. In the absence of action when staff had raised significant events staff did not have confidence that when raising poor performance that this would be dealt with. 	

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.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

Well-led rated

Rating: Inspected but not

We rated the practice as requires improvement for well led services in November 2021. At the time of this inspection the practice was continuing to work towards an action plan to meet the requirements of breaches we found during the inspection in November. At this inspection we found that:

- Leaders were not always visible.
- Due to low staffing the practice at times had not been able to achieve high quality sustainable care.
- The practice were working towards an improvement programme addressing staffing challenges by recruiting locum GPs and actively recruiting for more nursing and reception staff.

Leadership capacity and capability

Leaders could not 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.	Partial
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	No
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • On the day of inspection, we were told that a significant challenge was staffing. The practice had successfully appointed new members of the team and were continuing to advertise. On the day of our inspection staffing had improved however, following our inspection we were notified of further vacancies due to staff leaving. • Staff reported that during the past six months leaders were not visible. Since our inspection in November 2021 the majority of the practice team had changed. We were told by the senior management that there was always a member of management overseeing the practice. However, staff we spoke with told us that there was not always a member of management within the practice. 	

Vision and strategy

The practice had a clear vision, but it was not supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial

Progress against delivery of the strategy was monitored.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Due to the pressure of the practice within the past six months, the provider had concentrated on trying to meet the demands of the day to day running of the practice but acknowledged there were gaps in some areas. • Staff we spoke with felt that the provider vision and values were not always adhered to by members within the senior management team. • The practice had provided the CQC with an action plan following our previous inspection in November 2021. The provider had requested an extension of the action plan due to difficulties to achieve within the time scale. Staff we spoke with felt pressured to achieve the action plan and felt the timescales were unrealistic. • Due to low staffing the practice at times had not been able to achieve high quality sustainable care. However, had increased staffing in clinical and nonclinical areas to improve care. 	

Culture

The practice culture did not effectively support high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Partial
Staff reported that they felt able to raise concerns without fear of retribution.	Partial
There was a strong emphasis on the safety and well-being of staff.	Partial
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Partial
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Staff we spoke to explained that their wellbeing had become affected due to increased workloads and staff shortages. The leadership team explained they were aware that staff had worked through a difficult period and to recognise concerns a listening clinic was held with the Medical Director and Deputy Director of operations and nursing in May 2022. The listening clinic was held at the practice in a room and staff were invited to attend to give honest feedback and to raise concerns. Feedback from the listening clinic identified themes of poor communication and staff experiencing anxiety due to a lack of continuity and stability. Risks were identified which included administration staff making decisions outside of their level of competency, under reporting of significant event incidents and a lack of staff. There was an ongoing action plan which included further training for staff and rotating visible management on site. We were told there would be a repeat listening clinic, but a date had not been decided. However, whilst staff were encouraged to attend the event not all staff felt able to raise concerns. • The practice had access to a freedom to speak up guardian. However, not all staff were aware of who or how to contact the guardian. 	

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

Source	Feedback
Interviews with staff	We spoke with staff and found some staff were happy with the recent changes and felt the practice was in a better position at the time of our inspection in comparison to previous months. However, most staff members we spoke to were unhappy. We were told that the management of the practice were not always visible, and that staff wellbeing was being affected with staff reporting stress related sickness. Staff we spoke to were unsure of their immediate future at the practice and felt the practice had operated unsafely during previous months but acknowledge improvements had been made.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
Staff were clear about their roles and responsibilities.	No
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The management team we spoke with were unclear regarding who was responsible for certain roles and responsibilities. For example, investigating significant events. There was a management structure which included four managers, not all staff were clear of the roles and responsibilities of each manager. 	

Managing risks, issues and performance

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

	Y/N/Partial
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There was a patient safety risk assessment in place from March 2022 which included potential risks to patients and staff with a reduction in staffing. There was on occasions periods where there was not clinical cover due to being unable to secure Locums or bank staff. The leadership successfully appointed locum cover in May 2022 to reduce the risk. 	

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.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Partial
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had recently implemented a digital app for patients to book appointments. We asked but were not provided with how many patients had signed up to the service. We asked how the needs of digitally excluded patients were considered and were told they had the option to book via telephone or by accessing the surgery. However, on the day of inspection we found patients to be signposted to the online application without any additional checks of potential digital exclusion. The recently implemented digital app allowed patients to write down their symptoms or problems and the GP could identify and contact patients who required a face to face appointment. The practice had followed recovery plans to manage backlogs of activity that had occurred during the spring of 2022. 	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Staff views were reflected in the planning and delivery of services.	Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<p>Explanation of any answers and additional evidence:</p>	

- The leadership had held a listening clinic in May 2022 to gather views from staff. However, staff felt that their views were not always listened to or acted upon.
- The practice was in contact with the clinical commissioning groups to share the challenges that the practice was facing.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	No
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Due to periods of staff shortages continuous learning and improvement had not been implemented. For example, on the day of our inspection we found staff who had not completed the mandatory training required. Staff newly appointed had not received training. We were told that some staff would have their training period extended due to not being able to complete their induction programme because of a staff shortage. • Learning was not shared effectively for example; significant events had not been reviewed or actioned and learning was not shared. The practice told us that staff meetings were conducted weekly however; we were told by staff these were cancelled due to sickness and three had occurred during a three month period. On viewing the staff meeting notes there was no evidence of learning however, discussions to make improvements was noted. 	

Examples of continuous learning and improvement

The practice had recently implemented a new digital app which enabled patients to request appointments for telephone or face to face, request prescriptions and ask questions. The practice had appointed a duty GP to respond and book patients as required throughout the day. On the day of inspection, we found the telephone calls to the practice had significantly reduced.

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.
- **UKHSA:** UK Health and Security Agency.
- **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.
- ‰ = per thousand.