

Care Quality Commission

Inspection Evidence Table

Alconbury & Brampton Surgeries (1-569340564)

Inspection date: 3 August 2022

Date of data download: 26 July 2022

Overall rating: Good

Safe

Rating: Good

Safety systems and processes

The practice had 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.	Yes
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
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
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 ¹
Explanation of any answers and additional evidence:	
1. We saw evidence of clinical meetings held twice a month to discuss safeguarding. Safeguarding leads, health visitor and school nurses attending these meetings. The practice told us they had regular engagement with the health visitor and could contact them if they had concerns about children or needed advice.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes

Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
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Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 01/12/2021	Yes
There was a fire procedure. Date of fire risk assessment: 01/12/2021	Yes
Actions from fire risk assessment were identified and completed.	Yes ¹
Explanation of any answers and additional evidence:	
<p>1. The practice had undertaken a fire risk assessment and noted actions to take at both sites. Actions at Alconbury included removing an excess of notes in the secretaries room, the practice had acted upon this and notes had been placed in lockable cabinets. Actions at Brampton included reinstating weekly fire tests, we saw evidence of checks being carried out and documented online and staff would be alerted to complete these weekly.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 21/12/2021	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes ¹
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence:	
<p>1. We found evidence of actions taken from the infection prevention and control (IPC) audit including damaged sinks that had been replaced and signage for hand hygiene was placed at every hand wash area. The practice told us they had risk assessed the outstanding recommendations to remove carpets from the consultation areas to improve IPC. The practice evidenced a schedule of deep cleaning that had taken place alongside risk assessments for each room to mitigate the IPC risk. Where appropriate, carpets were also being updated in non-clinical consulting rooms.</p> <p>During the inspection the practice told us the staff had lunch in a large consulting room due to lack of space in the practice. The practice had risk assessed the room and mitigated the risk by reducing the patient footfall in the area. The practice told us of plans to separate the rooms so staff had their own dedicated staff room.</p>	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes ¹
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> The practice evidenced a spreadsheet to forecast staff shortages in each team alongside the patient list growth. This meant the management team were able to recruit to meet the demand. Staff were trained to cover other roles when there were shortages, some staff were on zero hour contract to allow for flexibility of support. 	

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.	Partial ¹
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.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> We found a summarising backlog of 322 patient notes, the practice was aware of the backlog and we found evidence of a decrease of summarising notes over the last 12 months, the practice evidenced an action plan to support this. The practice provided evidence of their list growth and we could see on average they were registering 80 to 100 new patients every month for the past three years which had an impact on their summarising backlog. We found medical records were easily accessible if the GP required them. 	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	1.13	0.87	0.79	Tending towards variation (negative)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2021 to 31/03/2022) (NHSBSA)	11.1%	10.7%	8.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022) (NHSBSA)	5.51	5.21	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	164.4‰	120.9‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.51	0.65	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	4.8‰	5.8‰	6.8‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

Any additional evidence or comments

The practice was aware of the number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR) was higher than the national average. The practice worked proactively with yearly audits and training to support this performance. The Integrated Care Board (ICB) medicines team had visited the practice to provide educational sessions on prescribing. The practice also had an antibiotic steward and a primary care network (PCN) clinical pharmacist working towards quality work to improve prescribing in the practice.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes ¹
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial ²
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> As part of our inspection and with the consent of the practice, we used a suite of clinical searches and reviewed some patient medical records. Two of these searches related to high-risk medications known as Disease Modifying Antirheumatic Drugs and found that all 60 patients receiving Methotrexate had the required monitoring and all 18 patients receiving Azathioprine had the required monitoring. On the day of inspection we found the paediatric oxygen masks had an expiry date of May 2022. The practice were aware of this and evidenced an order dated July 2022. However, the systems in 	

Medicines management**Y/N/Partial**

place were not wholly effective as they did not include paedatric oxygen mask on their check, which caused a delay in ordering. The practice took immediate action and updated their check list. We found no other concerns with emergency medicines or equipment.

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Yes
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Yes
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Yes
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Yes
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Yes
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Yes
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Yes
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Yes ¹
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Yes
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Yes
<p>Explanation of any answers and other comments on dispensary services:</p> <p>1. Dispensing incidents were recorded, reported and discussed within the dispensary on the day of the incident, the dispensary staff had meetings quarterly where they would review and discuss cases. We found dispensary staff were knowledgeable in their role and provided evidence of staff competency checks which were carried out annually.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made 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.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	43
Number of events that required action:	42
Explanation of any answers and additional evidence:	
We reviewed the practice records for recording events and outcomes. We found the practice had a robust system to ensure events and learning were shared with all team members which was evidenced in meeting minutes.	

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

Event	Specific action taken
Letter scanned to incorrect patient file	No confidentiality breach as staff corrected mistake, to be extra vigilant when scanning documents to ensure correct patient details are present.
Full prescription not given to patient	Patient unable to administer medicine, this was rectified. Prescribing procedure reiterated to follow process.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence:	
The practice told us alerts were received by the practice manager and pharmacist via email and via an online system. The manager and pharmacist cascaded alerts via the online system, staff were prompted to acknowledge receipt of the alert. The clinical staff would then conduct searches to understand what action was needed and alert staff, all alerts were reviewed at monthly clinical meetings where actions were discussed.	
We saw examples of actions taken on recent alerts for example, regarding hydrochlorothiazide and the increased risk of skin cancer. 15 patients had been identified and all had received information regarding this. A second search identified 138 patients taking Sodium-glucose Cotransporter-2 (SGLT2)	

inhibitors, and as a result have a small increased risk of Fournier's gangrene. Every patient in receipt of this medication had a letter detailing this risk.

Effective

Rating: Good

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

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 ¹
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes ²
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
Explanation of any answers and additional evidence: <ol style="list-style-type: none">1. As part of our inspection and with the consent of the practice, we used a suite of clinical searches and reviewed some patient medical records. We found medication reviews were structured and effective to help manage patients medication and provide safe care and treatment.2. The practice told us they had improved the delays in non urgent referrals within the last six months from four weeks delay to two weeks. The delay was because of change of staff and the training required once hired and the continuing increase in patient list size. The practice told us and we found evidence that two week wait referrals were actioned within 24 hours.	

Effective care for the practice population

Findings

- 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.
- 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.
- 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. The practice had identified 1790 patients and had currently carried out 226 health checks.
- All 57 patients with a learning disability were offered an annual health check, the practice had completed 56.
- 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.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice had registered 70 refugees from Ukraine and Afghanistan in the last six months, they had provided enhanced health checks and immunisations when needed.
- The practice had a nominated carers champion at both sites with designated training who led on ensuring patients were directed appropriately when in need of support.
- The practice staff attended the village fete in Alconbury with the patient participation group (PPG) to promote health education for the practice population. Health care assistants (HCAs) attended to take patients' blood pressures and encouraged them to attend the surgery if they had not done so recently. The social prescriber explained their new role at the practice and how they offered additional help and support to patients. The primary care network (PCN) paramedic demonstrated how to use a defibrillator and perform CPR as there were now defibrillators located within the community. The practice told us this encouraged engagement from a wide range of patients.

Management of people with long term conditions

Findings

- We found all 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. For example, the practice evidenced involvement from the community diabetes team for the more complicated patients with diabetes mellitus. We found the practice used a pharmacist who led on asthma reviews and we found detailed and robust care plans for these patients.

- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- 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 diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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)	143	151	94.7%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	120	127	94.5%	Met 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)	121	127	95.3%	Met 95% WHO based target
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)	119	127	93.7%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR)	162	176	92.0%	Met 90% minimum

(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>

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	78.6%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	51.4%	55.7%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	73.0%	68.0%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	64.8%	61.2%	55.4%	No statistical variation

Any additional evidence or comments

The practice was aware of their uptake in respect of cervical screening from December 2021. The practice told us appointments are available throughout the week so patients can attend when it suits them. They proactively contacted and monitored patients who had failed to attend, they also worked closely with West Cambs Federations and the practice were able to book extended access appointments directly through their system. In October 2022 the practice will be a hub to deliver these extended access appointments increasing the accessibility for patients. Until new data is published, we are unable to assess whether the actions taken have improved uptake.

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

<p>The practice had a programme of targeted quality improvement such as clinical audits.</p> <p>An audit conducted in January 2022 in respect of patients who had a levonorgestrel Intra-uterine system (IUS) fitted and did not have a diary entry for the removal, or change date on the system identified 30 patients with an IUS fitted of which 22 patients did not have a diary entry.</p> <p>The practice identified reasons for missing diary entries such as:</p> <ul style="list-style-type: none"> • Some doctors were not logging the diary date for changing the device at the time of insertion because they had previously worked at GP surgeries where this was not standard practice. • There had been an update to the insertion template which was not systematically being used. • A previous policy existed, whereby, for women aged over 45, their IUS did not require removing if it were being used for contraception alone. <p>The practice provided an educational session to discuss the findings and shared learning with the clinical team.</p> <p>The second cycle was in June 2022, 12 patients were identified with IUS fitted of which six patients did not have a diary entry.</p> <p>The practice identified further training of staff to remind them to use the appropriate templates for documenting an IUS insertion, ensuring that a diary date for removal has been entered.</p>

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.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
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
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes ¹

There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence:	
<p>1. Staff told us they had easy access to GPs for clinical support should they need it. The duty doctor had slots allocated for supporting staff each day, we saw evidence of monthly educational meetings where the GP nurse lead would meet with the nurse team and discuss and analyse random cases.</p> <p>The practice provided evidence of regular audits including cervical screening audits which were discussed with nurses. The nurses and dispensary staff had competency checklists which were reviewed annually by their specific lead, these checks were used to identify further training needs. All clinical staff had annual appraisals and annual assessments so the leaders could support and develop their team.</p>	

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

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.	Yes ¹
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence:	
<p>1. The practice told us they supported carers with flexibility in appointments where needed, inviting the carer to health reviews with the practice nurse annually, offering flu vaccinations. The practice also referred to social services, respite care, carers support group and Huntingdon carers support project. The practice had carers champions at each site who had completed training and attended</p>	

regular updates with Caring Together, this assisted them in their provision of support and information to carers within the practice population.

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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes

Well-led

Rating: Good

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.	Yes
They had identified the actions necessary to address these challenges.	Yes ¹
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ol style="list-style-type: none">1. The practice leaders could evidence actions they had taken to address challenges to quality and sustainability. These actions included spreadsheets used to monitor performance and staffing levels required to meet targets, this monitoring ensured the practice could recruit effectively to meet the demands of growth in patient list size and continue to provide quality care. The practice leaders provided evidence of risk assessments and their risk assessment protocol, this was embedded in their systems and processes and discussed in monthly meetings to allow the leaders to identify upcoming risks.	

Vision and strategy

The practice had a clear vision and 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.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes ¹
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: <ol style="list-style-type: none">1. We found the practice's mission statement was displayed in staff areas and on the practice computer system. Staff told us they were aware of the statement and their own values were in line with the practice's. Staff were aware of their role and how it was instrumental in how the practice performed.	

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.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes ¹
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence:	
<p>1. Staff told us they felt supported by the team and leaders at the practice, policies were in place to protect staff from abuse and keep them safe at work. Staff told us about team building activities outside of work and they had received self-care bags on an adhoc basis, an example of this was during the COVID-19 pandemic when the practice had given staff a gift bag with face masks, hand sanitiser, hand cream, sweets and scented candles for their continuing hard work.</p>	

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

Source	Feedback
Staff questionnaires and feedback	<ul style="list-style-type: none"> Staff told us there was good team work, there was a positive working environment and a high standard of care being delivered. Staff told us leaders were knowledgeable and supportive. Staff told us the practice was well organised and a safe working environment.

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.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes

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.	Yes
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

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 ¹
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
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> <ol style="list-style-type: none"> 1. The practice offered a range of appointments to meet the needs of the patient population including telephone and face to face when needed. The practice gave examples such as realising at the start of the pandemic that people with mental health issues were reluctant to consult on the phone and preferred face to face contact, the practice offered these appointments throughout. The practice added an alert when needed for patients with memory difficulties and would contact them an hour before their appointment as a reminder. They also maintained 	

dementia reviews, as they realised this group of patients were especially vulnerable during the pandemic.

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.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes

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.	Yes
The practice had an active Patient Participation Group.	Yes ¹
Staff views were reflected in the planning and delivery of services.	Yes

The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
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Explanation of any answers and additional evidence:
 1. The practice had 15 active members which formed their Patient Participation Group (PPG). The practice manager and a GP partner attended meetings which were held quarterly to discuss practice information.

Feedback from Patient Participation Group.

Feedback

Members of the PPG told us they were happy with the practice's engagement and how open and honest they were with the group. They told us the practice was accessible throughout the COVID-19 pandemic and that they felt safe when visiting the practice.

Any additional evidence

How the Patient Participation Group and the practice support each other and their patients:

- Car scheme run by volunteers to support the community to attend health care appointments, the volunteers charged a small fee which was then given back to the practice to improve the facilities provided.
- Practice remained open during the pandemic and communication was good informing PPG and patients of changes.
- Practice and PPG supported each other with the COVID-19 vaccinations programme.
- PPG raise money for the surgery through village fetes where the practice staff joined, they have raised money to buy blood pressure machines and a phlebotomy chair.
- Food banks placed at both practices.

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.	Yes
Learning was shared effectively and used to make improvements.	Yes

Examples of continuous learning and improvement

The practice continued to develop their staff through learning opportunities, staff told us of additional courses they had attended and qualifications gained with the support from the practice. For example, the practice had supported a staff member to undertake an apprentice pharmacist course.

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. 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.