

# Care Quality Commission

## Inspection Evidence Table

### Huntingdon Road Surgery (1-572243015)

Inspection date: 01 October 2021

Date of data download: 01 October 2021

## Overall rating: Good

At our previous inspection in December 2019 we rated the practice as requires improvement overall. We identified issues relating to the management of risks, inadequate infection control audits and a lack of clinical oversight on blood tests for specific medicines. At this inspection we found that improvements had been made, risk assessments were in place, infection control procedures and systems for the management of medicines had been strengthened. We have now rated the practice as good overall.

## Safe

## Rating: Good

At the previous inspection we rated the practice as requires improvement for providing safe services. The provider was unable to demonstrate effective risk assessments were in place, which included infection control audits and the management of specific medicines needed strengthening. At this inspection we found the practice had addressed all the concerns identified. We have now rated the practice as good for providing safe services.

### 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.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y

Safeguarding	Y/N/Partial
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.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Staff we spoke with were aware of who they needed to go to if they had safeguarding concerns. There was a safeguarding lead in the practice and a safeguarding administrator who had implemented a range of processes to monitor the registers and ensure they were kept up to date. This included sharing information with other agencies if patients moved between services</li> <li>• There were comprehensive policies and procedures for safeguarding children and vulnerable adults. These were reviewed and updated to reflect any changes and were accessible to staff.</li> <li>• Staff files reviewed demonstrated that Disclosure and Barring Service (DBS) checks were in place for staff as part of pre employment checks. This included enhanced and standard DBS checks based on the role and responsibilities of the job. DBS checks identify 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.</li> <li>• All staff had completed training relevant to their role. This included level three safeguarding training for clinical staff.</li> <li>• Multi-disciplinary team meetings were generally held every month. The meetings were organised with the health visiting team and the school nurse.</li> </ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• We reviewed a range of personnel files for staff. We found all the appropriate checks had been carried out prior to employment.</li> <li>• An induction checklist was in place for each staff member tailored to their role</li> <li>• At the last inspection we found the immunisation matrix the practice had in place to identify staff's immunisation status had not been updated. At this inspection, we found an immunisation policy was in place which was reviewed and updated yearly with recommended guidelines and a clear process was in place to identify the vaccination status of staff.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Y
There was a fire procedure.	Y
Date of fire risk assessment: August 2021 Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	

- At the previous inspection the practice were unable to demonstrate that portable appliance testing (PAT) had been carried out. At this inspection we found PAT testing had been completed in August 2021. Calibration testing had also been completed in June 2021.
- Health and safety risk assessments were identified as being generic and did not demonstrate specific information to ensure risks were adequately monitored at the previous inspection. We found this area had been strengthened with a range of risk assessments in place and monthly checklists were carried out to identify any potential risks within the building.
- There was a fire safety policy in place and nominated fire marshalls. Documents seen showed that fire equipment was regularly serviced. The practice tested fire alarms and carried out regular fire drills to ensure staff knew what to do in the event of a fire.
- The practice had a range of risk assessments in place, these included fire, health and safety and the Control of Substances Hazardous to Health (COSHH).

## 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.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: Cleaning audit September 2021 Buildings infection control audit: May 2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• At the previous inspection, the practice was unable to demonstrate the entire practice premises had undergone an infection control audit and some audits had not been undertaken since 2016. At this inspection we found monthly cleanliness audits were in place and a buildings inspection audit had been completed in May 2021.</li> <li>• To ensure the safety of both staff and patients during the COVID-19 pandemic, clinical staff were given time between seeing each patient to clean their consulting rooms.</li> <li>• Staff had completed infection prevention training relevant to their role. There was an infection control lead in place.</li> <li>• Due to the COVID-19 pandemic, the practice had increased the frequency of cleaning, ensured there was adequate personal protective equipment available and carried out spot checks throughout the week to ensure control measures to minimise the spread of infection were being adhered to.</li> <li>• Policies, procedures and audit templates were in place for infection prevention and control and accessible for all staff.</li> <li>• We observed the general environment to be clean and tidy with the layout and facilities of the premises changed in line with COVID-19 guidance for infection prevention and control.</li> </ul>	

## 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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
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.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice told us they had been able to manage the practice sufficiently during the COVID-19 pandemic. The practice had employed more staff to ensure there was adequate cover at all times. This included an increase in both clinical and non clinical roles.</li> <li>The practice had a range of equipment for medical emergencies and staff had completed training relevant to their role in sepsis awareness.</li> <li>At the previous inspection we found there was no system in place to monitor the secondary waiting room area at the practice which posed potential risks if a patient became acutely unwell. We found at this inspection that CCTV had been installed to monitor this area, with staff in reception monitoring the screens.</li> </ul>	

## 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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p>	

- The practice had a system in place for the management of referrals under the two week wait process. The practice secretaries processed the referral and monitored booking process to ensure the patient received an appointment.
- During the remote access of the clinical system we reviewed a random sample of patients records and found referrals and test results had been acted on promptly and in accordance with best practice guidance.
- The practice had a protocol in place for the management of test results. An audit process was in place to demonstrate clinical letters had been actioned.

## 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) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.45	0.74	0.69	Variation (positive)
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). (01/07/2020 to 30/06/2021) (NHSBSA)	8.9%	12.2%	10.0%	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 (01/01/2021 to 30/06/2021) (NHSBSA)	5.20	5.26	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	40.9‰	118.0‰	126.1‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	0.48	0.68	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	3.2‰	5.8‰	6.7‰	Variation (positive)

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
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.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
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.	Y
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.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
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.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
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.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• There was clinical oversight for all requests for medicine changes and a clear process was in place to demonstrate what actions had been taken.</li> <li>• During our remote clinical review of patients prescribed Methotrexate, we found a total of 44 patients were prescribed this medicine and on reviewing five records we found the appropriate monitoring was in place.</li> <li>• We carried out random searches of patients prescribed high risk medicines and on reviewing a sample of patients' records we found prescribing was in line with guidelines and regular reviews were in place.</li> </ul>	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> <li>• Emergency medicines and vaccines were appropriately stored and there were clear monitoring processes in place.</li> <li>• Medicine fridges were monitored to ensure they were maintained at the correct temperatures for storing vaccines and other relevant medicines.</li> </ul>	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
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.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y
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.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
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.	Y
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Y
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y
<p>Explanation of any answers and other comments on dispensary services:</p> <ul style="list-style-type: none"> <li>• At the previous inspection we found the practice were unable to demonstrate how prescription stationery was monitored at the branch site. During this inspection we carried out a visit to the Girton branch site and found processes had been strengthened to ensure prescription stationery was monitored and stored securely.</li> <li>• There were processes in place to ensure any incidents were recorded and actioned appropriately. Learning was shared amongst the team to mitigate future risks.</li> </ul>	

## 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.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	9
Number of events that required action:	9
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>Staff were encouraged to report incidents to the management team. The practice had a record of significant events and incidents that had occurred and the learning outcomes.</li> <li>We saw from the minutes of practice meetings that incidents were regularly discussed and learning shared.</li> </ul>	

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

Event	Specific action taken
Blood sample left in cupboard overnight	<ul style="list-style-type: none"> <li>Discussed with the practice team to ensure they were more observant when collecting specimens.</li> <li>The safety of specimens was re-iterated and improvements were implemented to ensure all specimens were taken to the main collection point and deposited in the appropriate collection bags.</li> </ul>
Partial building power outage which affected the computer server, fridges and telephones	<ul style="list-style-type: none"> <li>Business continuity plan was put into action.</li> <li>Discussed as a team and business continuity plan circulated to all staff again.</li> <li>Staff made aware of where the plan was kept.</li> </ul>

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>We looked at a range of safety alerts and found these had been actioned appropriately.</li> <li>Results from our clinical searches showed that the practice had taken the appropriate action on a safety alert for specific medicines which placed unborn children at risk if taken by mothers when pregnant. We found four patients on this medicine and evidence showed each patient had received advice on the risks related to pregnancy or were being monitored by secondary care.</li> </ul>	



## Effective

## Rating: Requires improvement

At the previous inspection we rated the practice as requires improvement for providing effective services. We found exception reporting data for long term conditions was significantly higher than England averages, national screening targets were lower than national averages and some staff had not received an appraisal in the previous 12 months. At this inspection we have continued to rate the practice as requires improvement for providing effective services as the practice continued to have childhood immunisations and screening targets below national averages.

*Quality and outcomes framework (QOF) requirements were modified by NHS England 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.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>• Medication reviews were being carried out and on reviewing a sample of patients records we found them to be in line with recommended guidance.</li><li>• The practice had clinical leads in place to ensure the appropriate monitoring was in place.</li><li>• Monthly multi-disciplinary team meetings were held to ensure patients care was co-ordinated across various teams. Local community nursing teams and the hospice attended on a regular basis.</li></ul>	

## 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.
- The clinical team had carried out a COVID-19 vaccination programme for care home residents registered with the practice. Online meetings had been organised with a community geriatrician to discuss complex older patients' needs.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- The practice had not met the minimum 90% uptake rate for four of the five childhood immunisation indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for any childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice had not met the national target of 80% for cervical screening. The practice had seen a further decrease in the number of patients who had been screened since the previous inspection.
- 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.
- Staff who worked in a health and social care setting were offered a range of week day and weekend appointments for COVID-19 vaccination. Pop up vaccination clinics were implemented which provided walk-in access for patients who had been unable to make appointments elsewhere.
- All patients with a learning disability were offered an annual health check. The practice had worked in partnership with other service providers to ensure patients with a learning disability received a covid vaccine.
- 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 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 invited a representative from the Alzheimer's Association to lead a training session with the practice team. Thirty members of the team attended to gain a better understanding. The team had become Dementia Friends to provide support to patients and their families.

## Management of people with long term conditions

### Findings

- Clinical staff spoken with provided some examples of how they delivered effective care to older patients such as referring to social prescribers.
- Some patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. However, during the remote review of the clinical system we searched for patients with suspected diabetes. We found eight patients with a potential missed diagnosis of diabetes. On reviewing a random sample of five patients records, we found three patients had not received the appropriate follow up.
- During the remote search of the clinical system we found a total of 20 patients who had been prescribed more than 12 inhalers in the previous 12 months. On reviewing a random sample of five patients' records we found three were overdue a review. We were told that to improve diagnostics and management of patients newly diagnosed or with severe asthma, the practice had implemented a new form of testing. The practice planned to review on average 10 patients per month.
- 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) (01/04/2019 to 31/03/2020) (NHS England)	105	115	91.3%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received	115	135	85.2%	Below 90% minimum

Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)				
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)	112	135	83.0%	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)	118	135	87.4%	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)	95	126	75.4%	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 were aware of their lower than national average for childhood immunisations and had implemented processes to follow up on children who failed to attend their appointments.
- A weekly report was completed to identify new mothers. An invitation was sent out for the child's first immunisations.
- Patients that continually failed to attend appointments were referred to the GP for further action.
- Regular meetings were held with the health visiting team to discuss concerns.

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)	49.8%	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)	66.0%	68.1%	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)	62.9%	63.6%	63.8%	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)	61.5%	62.2%	54.2%	No statistical variation

#### Any additional evidence or comments

- The practice had tried to encourage patients to attend cervical screening appointments. During the COVID-19 pandemic the practice continued to offer appointments.
- If patients failed to attend their appointments, after the second invite one of the nursing team contacted them to discuss their concerns and to offer support and advice.

## 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.	Y
The practice had a programme 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

An audit was carried out to identify patients who were taking a specific high risk medicine used as an immune-suppressant for a range of health conditions to ensure patients were up to date with their monitoring. The audit identified 26 patients prescribed this specific medicine. On reviewing each patient, the practice found two patients were not prescribed the medicine, however the medication template had not been updated. Further review of patients showed 83.3% were up to date with their monitoring and half of the remaining patients had an appointment confirmed for their blood monitoring. The remaining patients were contacted to attend a review appointment.

### Any additional evidence or comments

At the previous inspection we found the clinical staff were unable to provide evidence they had a clear process in place for reviewing blood tests prior to prescribing warfarin. At this inspection we found the practice had carried out an audit to identify patients on this specific medicine to check they had received the appropriate blood monitoring in the previous 12 weeks.

The audit identified 33 patients were prescribed warfarin. On reviewing each patient, the practice found all patients had the appropriate tests recorded within the previous 12 weeks.

## 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 programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• A system was in place to monitor and review staff training and we saw high completion rates for training specified as mandatory by the provider.</li> <li>• Discussion with clinical and non-clinical staff demonstrated awareness and understanding in areas such as safeguarding and responding to an emergency.</li> <li>• At the previous inspection we found some staff had not received an appraisal in the previous 12 months. At this inspection we found there was evidence of staff appraisals and staff reported they were encouraged and given opportunities to develop.</li> </ul>	

## 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-centred care when they moved between services.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The provider held regular monthly meetings in which they discussed the practices most vulnerable patients. We saw from the minutes of the meetings that the district nursing team regularly attended.</li> </ul>	

- The GPs met weekly to discuss patients and update each other on guidance. The community based health teams were able to directly input information onto the clinical system to ensure important information was shared about the care and treatment of patients across services.

**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

Explanation of any answers and additional evidence:

- The practice had a programme of quality improvement to ensure clinical registers were up to date and patients received the appropriate reviews and monitoring. A range of templates were in place to monitor the effectiveness of the registers.
- The practice had been allocated a social prescriber through their Primary Care Network. The practice told us they were pro-active in referring patients for support and guidance.
- The practice had been certified as a Parkrun practice. This was an initiative which enable GPs and practice staff to socially prescribe physical activity by referring patients to take part in a park run to support their health and wellbeing.

**Any additional evidence or comments**

The practice had updated their website to ensure patients had clear information on how to access support and current guidelines. For example:

- A COVID-19 vaccination page had been implemented which provided clear instructions on the vaccine rollout.
- A Student page had also been added. This page explained how college nurses interacted with the practice and how students could access medical care. Feedback from the practice highlighted that 30% of their practice population were students, so having up to date information and working closely with the college nurses, students were able to access care in a timely manner.



## 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

## Well-led

**Rating: Good**

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>• Leaders understood the challenges impacting on the delivery of the service which included access to appointments and the impact of the COVID-19 pandemic. They had taken action to improve patients' experience which included an increase in GPs to offer more appointments.</li><li>• Staff told us that leaders were approachable and supportive and staff engagement was encouraged.</li><li>• Staff reported that they felt well-led and part of a team. There was strong collaboration and support across all teams and a common focus on improving the quality of care and people's experiences.</li><li>• Staff met regularly to discuss any issues or complex cases and to offer and receive peer support.</li></ul>	

### 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.	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"><li>• The practice had a clear vision which was shared with staff through meetings and updates.</li><li>• Discussions with staff reflected the practice vision and values.</li><li>• Staff told us the aim was to be a caring practice, delivering safe, high quality care.</li><li>• The practice had set out their plans and priorities for the coming year in their business plan and staff worked together to address those priorities.</li></ul>	

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• There was emphasis on staff wellbeing, and this was demonstrated through discussions with staff and evidence of appraisals.</li> <li>• There was a policy for whistle blowing which allowed staff to understand the process and refer any concerns.</li> <li>• Practice meetings took place which provided an opportunity for staff to discuss issues.</li> <li>• Staff said they were confident to raise any concerns and felt they would be listened to.</li> <li>• The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.</li> </ul>	

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

Source	Feedback
Staff	We spoke with a range of staff during the inspection. Staff told us they were well supported; management were approachable, and they worked together as a team.

## 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
Explanation of any answers and additional evidence:	

- At the previous inspection we found the practice was unable to demonstrate fully developed and effective governance processes were in place. At this inspection we found the practice had carried out a review of their processes and had implemented and strengthened their governance structures. This included the recruitment of new staff to further enhance the current team and a review of their risk assessment management. For example: Infection control audits had been strengthened to ensure the appropriate measures were in place.
- During this inspection, we found formal systems were in place to monitor the quality of services provided. The practice had a range of regular audits to ensure quality indicators were reviewed, risks were identified and there was a structured approach to support the governance arrangements.
- Policies and procedures were available on an electronic system which were accessible to all staff. Discussions with staff showed understanding and awareness of key policies such as safeguarding and whistleblowing.
- Discussions with staff and evidence reviewed from clinical records demonstrated patients care and treatment was delivered with effective governance structures and systems and with clinical oversight. On reviewing a random sample of patients' records we found patients' care and treatment was delivered in line with recommended guidance.
- All clinicians attended a weekly meeting which was the forum at which significant events analyses, complaints, safety alerts, new policies and procedures were discussed as well as any clinical concerns.
- Communication was effective and organised through structured, minuted meetings.
- All clinicians met daily to discuss work prioritisation and vulnerable patients as well as difficult cases and current events. Key community team members were invited regularly to attend meetings, these included district nurses, college nurses and health visitors.

## 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 programme 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The provider had undertaken several risk assessments relevant to the provision of clinical care, including infection control and premises risk assessments. Recommendations from risk assessments had been actioned.</li> </ul>	

- The practice had a range of risk assessments in place, for example, fire, health and safety, and infection control.
- There was a programme of clinical auditing in place to monitor quality and implement improvements. The programme was regularly reviewed and updated to ensure there was a formal analysis of quality and sustainability at the practice.

### 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• All patients that requested to see a GP were first given a telephone appointment. Following the telephone review, the GP would make a clinical decision if a face to face appointment was required. Patients who attended the practice were asked a range of questions to ensure they had no symptoms in relation to COVID-19. Temperatures were taken, face masks were available if patients arrived without one and hand sanitizer was in place throughout the building.</li> <li>• Patients who were considered vulnerable had alerts on their clinical records to identify them.</li> <li>• Infection control processes had been strengthened and extra cleaning schedules had been implemented to ensure cleaning was carried out at frequent intervals. Clinical staff were given extra time between patients to clean their consultation rooms.</li> <li>• COVID-19 risk assessments had been completed for each member of staff. Staff that were identified as higher risk were supported to work remotely.</li> <li>• Due to the size of the building where the practice was situated, vulnerable staff had the facilities to work socially distanced from their colleagues.</li> <li>• The practice had a designated room for patients who arrived at the practice with symptoms of COVID-19 infection. This room was clearly marked. A second room was also available if needed to ensure patients were isolated appropriately.</li> <li>• The practice had implemented a standard operating procedure to ensure staff had the appropriate guidelines to give to protect themselves, patients and members of the public. The operating procedure provided clear guidelines on how to use personal protective equipment, handwashing techniques and the processes all staff had to follow mitigate potential risks.</li> </ul>	

- A pop up COVID-19 vaccination centre was set up on three weekends to provide access to patients and the local community who were unable to attend an appointment during the week.

## 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 entailed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• There were systems in place to monitor performance. A review of practice performance against the Quality Outcomes Framework (QOF) was carried out on a regular basis.</li> <li>• Systems were in place to ensure risk assessments were completed on a regular basis to manage and mitigate risks. Action plans were in place to address any concerns identified.</li> <li>• Clinical templates were embedded within the practice. This helped to reduce the variability in using read codes as well as improving the safety of work carried out by new members of staff, clinical trainees and locums. It promoted uniformity of record keeping with all clinicians.</li> </ul>	

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

Explanation of any answers and additional evidence:

- Online consultations took place in consultation rooms with the doors closed to protect the patients' privacy.
- A policy was in place to provide guidance to all clinical staff on the process to follow when carrying out remote consultations.

## 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:

- Staff feedback highlighted a strong team with a positive supporting ethos.
- Staff said the leadership team proactively asked for their feedback and suggestions about the way the service was delivered.
- The practice had an active patient participation group (PPG), whose opinions and feedback were valued by the practice team to inform their decisions. For example: A recent PPG initiative was an information leaflet specifically for students which would be emailed to the college student welfare officers to provide information on services available.
- The management team, GPs and lead nurse met every week. All staff in the practice were given the opportunity to contribute to the agenda through their specific line managers and information was disseminated after through each staff group representative. Regular meetings were also held within the teams to share information
- A weekly online huddle meeting was held to update staff with any changes. Minutes of all minutes are circulated to all staff.
- To understand the role of a carer, 50 of the staff at the practice had completed carers awareness sessions. The practice website had been updated to provide information on support available.

Feedback from Patient Participation Group.

#### Feedback

We spoke with a member of the participation group, who told us the practice had done an excellent job during the COVID-19 pandemic and found they received high quality care.

#### Any additional evidence

30% of the patients registered at the practice were students who attended the universities and colleges within Cambridge. The practice had created an information page on their website to offer advice and had

engaged with the college welfare officers to be part of the PPG. We were told this had improved communication with students and students were able to share their concerns and the issues they faced more easily.

### 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• Staff were encouraged to develop and were provided with training opportunities which were discussed at their appraisals.</li> <li>• The practice was a teacher and GP training practice and had widened their education facilities and now provided opportunities for student nurses and physician associates.</li> <li>• The practice had implemented a new project to improve the diagnostic accuracy and management of asthmatic patients. The plan was to implement a specific form of testing on new asthmatic and severe asthmatic patients. Evidence provided showed there was approximately 115 patients who would potentially benefit from the testing and reviews, on average 10 patients per month over a 12 month period.</li> <li>• Regular in-house education meetings were held and GPs from local practices and nurses from the colleges were invited to attend. A range of topics were discussed. For example: a review of significant events was held to share learning and to mitigate future risk.</li> </ul>	

### Examples of continuous learning and improvement

one of the GPs at the practice was the clinical director for the local primary care network, and had been involved in implementing a range of projects to improve the care of patients within the community. These included:

- Working with local mental health support groups to provide weekly virtual Good Mood Cafes to provide support and social connections for students attending the universities. Evidence provided showed 155 students had attended the virtual sessions, with body image and self compassion sessions being among the most popular.
- Fifty surgery staff across the PCN had completed Carers Awareness sessions with a carers organisation. Flyers were produced to encourage patients to register carers at their GP surgery and notice boards and information was added to practice's websites.
- The practice had recently implemented a teledermatology project to support the diagnosis of patients with skin conditions. The aim of the project was that patients with potential skin problems had a photograph taken by a professional medical photographer and the pictures were then sent to a specialist at the hospital for their review and comments.



## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.
- 
- $\%$  = per thousand.