

Care Quality Commission

Inspection Evidence Table

George Clare Surgery (1-566699871)

Inspection date: 22 and 29 March 2022

Date of data download: 22 March 2022

Overall rating: Good

We carried out a comprehensive inspection between 22 and 29 March 2022. The inspection included a remote review of patient clinical records, interviews with staff and a site visit. We undertook this inspection at the same time as CQC inspected a range of urgent and emergency care services in Cambridgeshire and Peterborough. To understand the experience of GP providers and people who use GP services, we asked a range of questions in relation to urgent and emergency care. The responses we received have been used to inform and support system wide feedback.

Following this inspection, we rated the location as good overall, and for all key questions.

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 |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none">All clinical and non-clinical staff we spoke with knew who the safeguarding lead at the practice was, how to access safeguarding policies and procedures and local safeguarding contact details. | |

| Safeguarding | Y/N/Partial |
|--|-------------|
| <ul style="list-style-type: none"> • There was a safeguarding team, overseen by the safeguarding lead, who ensured patient records were appropriately coded and risk registers were up-to-date. • We saw that clinical staff were trained to safeguarding children level three and non-clinical staff were trained to safeguarding children level two in line with national guidance. • As part of this inspection our GP specialist adviser reviewed three safeguarding records and found entries and actions to be appropriate. • Staff we spoke with were able to describe their role and responsibility when chaperoning. We saw that notices were displayed in consultation rooms to advise patients that a chaperone service was available, if required. | |

| 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 Public Health England (PHE) guidance if relevant to role. | Yes |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • We reviewed three clinical and one non-clinical recruitment file for staff who had been employed since our previous inspection. We found there was a system in place to check all relevant employment documentation in accordance with regulations, for example, photographic identification, references, Disclosure and Barring Service (DBS) and professional registration checks. • We saw the practice had a system in place to capture the immunisation status of staff at the point of recruitment. From the selection of employment records reviewed we found the immunisation status had been recorded. | |

| Safety systems and records | Y/N/Partial |
|--|-------------|
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: | Yes |
| There was a fire procedure. | Yes |
| Date of fire risk assessment: 5 July 2021 Actions from fire risk assessment were identified and completed. | Yes |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • The practice was located in a purpose-built medical facility which was owned by some of the partners. We saw that the practice had systems and processes in place to ensure premises and equipment maintenance were undertaken, for example the fire alarm system and fire extinguishers. • We saw the practice had systems and processes in place to ensure appropriate risk assessments were undertaken, for example fire, Control of Substances Hazardous to Health (COSHH) and Legionella. • We saw evidence that Portable Appliance Testing (PAT) had been undertaken in September 2021 and calibration of medical equipment had been undertaken in October 2021. • We saw evidence of a valid Gas Safety Certificate undertaken on 24 June 2021 and an Electrical Fixed Installation Condition report undertaken on 3 February 2020. • The practice had nominated five members of staff as fire marshals, who had undertaken training. | |

- We saw all staff had undertaken fire awareness training, which was updated annually.
- Staff we spoke with knew the location of the fire assembly point and told us there were regular fire evacuation drills undertaken. We saw from practice records that the last fire evacuation drill was undertaken on 17 March 2022.

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: March 2021 | Yes |
| The practice had acted on any issues identified in infection prevention and control audits. | Yes |
| The arrangements for managing waste and clinical specimens kept people safe. | Yes |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • On the day of the inspection we observed the premises to be clean and tidy. • Staff we spoke with described the processes to clean rooms between patients and told us they had access to appropriate personal protective equipment (PPE). On the day of the inspection we saw staff had access to adequate PPE. • All staff had undertaken infection prevention and control (IPC) training relevant to their role and refresher training was undertaken annually. The nominated IPC lead had not undertaken any training for the lead role. For example, training that included IPC knowledge in line with the Hygiene Code which identified specific primary care IPC responsibilities for this role. The practice told us at the inspection that they planned to organise appropriate training. • Bodily fluid spillage kits were available and all staff we spoke with knew where they were located and how to use them. | |

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 |
| 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 |
| Explanation of any answers and additional evidence: | |

- Clinical and non-clinical staff had undertaken annual basic life support training. Staff were aware of the location of emergency medical equipment and medicines, for example oxygen and the automated external defibrillator (AED).
- The practice utilised the panic alarm system integrated into their clinical system. Staff we spoke with were aware of how to raise the alarm in the event of an emergency.

Information to deliver safe care and treatment

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

| | Y/N/Partial |
|--|-------------|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. | Yes |
| There was a system for processing information relating to new patients including the summarising of new patient notes. | Yes |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. | Yes |
| Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals. | Yes |
| There was a documented approach to the management of test results and this was managed in a timely manner. | Yes |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | Yes |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • As part of our inspection, the CQC GP specialist advisor reviewed a selection of patient records without visiting the practice. These searches were visible to the practice. We saw that patient consultations contained appropriate information and demonstrated that care and treatment was being delivered in a safe way. • We saw that the practice audited the summarising of new patient medical notes against the criteria of their summarising protocol. • We saw that the practice had failsafe systems in place for safety-netting cervical screening undertaken at the service to ensure that a result was received for each cervical screening sample undertaken by their sample takers. We saw that an audit of this process had been undertaken. | |

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) (01/01/2021 to 31/12/2021) (NHS Business Service Authority - NHSBSA) | 0.90 | 0.80 | 0.76 | No statistical variation |

| Indicator | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------------------------|
| 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). (01/01/2021 to 31/12/2021) (NHSBSA) | 13.0% | 11.2% | 9.2% | Tending towards variation (negative) |
| 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 (01/07/2021 to 31/12/2021) (NHSBSA) | 5.34 | 5.18 | 5.28 | No statistical variation |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA) | 169.8‰ | 119.7‰ | 129.2‰ | No statistical variation |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) (NHSBSA) | 0.75 | 0.64 | 0.62 | No statistical variation |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2021 to 30/09/2021) (NHSBSA) | 8.7‰ | 5.8‰ | 6.7‰ | No statistical variation |

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

Any additional evidence or comments

The clinical team were aware that the prescribing of co-amoxiclav, cephalosporins and quinolones were above the local and national averages. The practice continued to work with the medicines optimisation team on prescribing outcomes. We saw that prescribing for co-amoxiclav, cephalosporins and quinolones had shown a reduction in each reporting quarter:

- March 2021 – 14.53%
- June 2021 – 13.79%
- September 2021 – 13.59%
- December 2021 – 13%

| 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 |

| Medicines management | Y/N/Partial |
|---|-------------|
| 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 |
| 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 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. | Yes |
| 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 PHE guidance to ensure they remained safe and effective. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>As part of our inspection, we conducted a series of searches to assess the practice's procedures around medicines management and prescribing. A review of the searches was undertaken by the CQC GP specialist advisor without visiting the practice. The searches were visible to the practice.</p> <ul style="list-style-type: none"> • We ran a search of patients prescribed three types of disease-modifying antirheumatic drugs (DMARDs) and found patients had received monitoring in line with guidance. For example, our search showed that 72 patients were on the DMARD methotrexate. We sampled five of those patients and found that all patients had been monitored appropriately. • We ran a search of patients prescribed six types of high-risk medicines. We found that although systems and processes were in place to recall and monitor patients in line with guidance there were a small number of patients who had not attended the practice for blood tests in a frequency in line with guidance. For example, some patients prescribed angiotensin-converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARBs), which are medicines used to treat raised blood pressure, had not had appropriate blood monitoring. Immediately after the inspection the lead GP reviewed all patients identified from our search and sent evidence that | |

| Medicines management | Y/N/Partial |
|---|-------------|
| all patients had been reviewed and contacted and offered an appointment for blood testing and monitoring. The practice told us they planned to undertake an audit of these patients in a month's time to ensure appropriate monitoring had been undertaken. | |

| 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. | Partial |
| 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. | N/A |
| Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence. | Yes |
| Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc. | Partial |
| 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> <ul style="list-style-type: none"> • Access to the dispensary was restricted to practice staff only, and several security measures had been installed, including lockable doors and cupboards, which were managed in line with their key holder policy. Cleaning staff were also granted access to the dispensary. At the time of our inspection that practice had not undertaken a risk assessment regarding this. Immediately after the inspection the practice provided a completed risk assessment. We saw that the practice had used the outcome of the risk assessment to refresh dispensary staff on the importance of ensuring all confidential information and medicines were securely locked away at night. As a result of our observations on the day of the inspection and their risk assessment we saw the practice had increased lockable cupboard storage. • The practice maintained a controlled drugs register, which recorded the concentration, quantity and condition of each drug. • Dispensary staff who worked unsupervised were experienced and appropriately trained to National Vocational Qualification (NVQ) Level 2. However, dispensary staff did not receive | |

ongoing or periodic supervision for their role to ensure competence was maintained by the provider. Immediately after the inspection the Lead GP told us they would discuss with the dispensary manager a proposed schedule of staff competence assurance and audits against standard operating procedures (SOPs).

- The practice did not offer a delivery service.
- Some information was available to patients in an accessible format for example, information leaflets could be printed in larger font size for patients with visual impairments. However, the printing system used in the dispensary did not allow for braille printed labels or larger print labels, which some patients may benefit from.

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 (clinical and non-clinical) recorded in last 12 months: | 93 |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • There was an incident policy in place, which was accessible to staff. • We saw the practice had a system to record all categories of incidents. For example, clinical, administrative and those from a third party where a registered patient may be affected. For example, patient feedback regarding a delayed discharge summary or delay in a secondary care referral appointment. • The practice told us it operated a low threshold of reporting and encouraged staff to report even minor incidents to drive quality improvement. The practice also captured patient feedback in the public domain, for example on social media, as part of their incident and complaints reviews and discussions. • The practice provided all documented incidents for 2021 and from January to February 2022. We reviewed the period April 2021 to February 2022 and found the practice had recorded 93 incidents. Of these incidents, 49 were classified as clinical, 29 as administrative and 15 as third party. • All staff we spoke with were aware of the process to record an incident and were able to give some recent examples. Staff told us they were encouraged to report any incident, no matter how small. Staff told us they felt confident they could report any incident. • At the inspection we reviewed a selection of non-clinical and clinical incidents and saw appropriate action had been taken and learning shared through meetings. | |

Example of significant events recorded and actions by the practice.

| Event | Specific action taken |
|--|---|
| Patient with the same name incorrectly booked in to see the GP | Staff refresher and reminder to check three patient identifiers (name, date of birth and address) when booking appointments for patients. |

| 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: | |
| <ul style="list-style-type: none"> The practice had systems and processes in place to receive, disseminate and act upon alerts received through the Medicines and Healthcare products Regulatory Agency (MHRA) and the Central Alerting System (CAS). We saw that a log was maintained of all safety alerts received and action taken. As part of our inspection, we conducted a series of searches to assess the practice's procedures for acting on alerts. A review of the searches was undertaken by the CQC GP specialist advisor without visiting the practice. The searches were visible to the practice. Our search included eight single drug safety alerts and three combination drug safety alerts. One search related to the appropriate dosage of two common medicines when prescribed together. Our search identified 12 patients who were prescribed both medicines. We undertook a detailed review of five patients' records and identified that the practice had recently reviewed the patients and made changes to their repeat prescription in line with guidance. | |

Effective

Rating: Good

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. | Yes |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Yes |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. | Yes |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Yes |
| Patients' treatment was regularly reviewed and updated. | Yes |
| There were appropriate referral pathways to make sure that patients' needs were addressed. | Yes |

| | |
|--|-----|
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Yes |
| The practice had prioritised care for their most clinically vulnerable patients during the pandemic | Yes |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • Clinicians we spoke with told us a clinical decision support tool was integrated into the clinical system which allowed easy access to the latest evidence-based guidance resources and templates. Staff told us this provided consistency, clinical effectiveness and safety. • The practice was a teaching and training practice and was proud of their strong emphasis on education. The practice held weekly educational meetings where new guidance was discussed. Staff told us that case-based discussions were held in these meetings and gave them an opportunity for retrospective evaluation of clinical decision-making in patient care. • We reviewed a selection of minutes and saw that a range of educational sessions had been held. For example, in November 2021 there had been a discussion around pregnancy-related issues, which included rashes and exposure to rashes in pregnancy, ectopic pregnancy and hypertension in pregnancy. We saw in December 2021 that the management of patients with neurodiversity, for example attention deficit hyperactivity disorder (ADHD), dyslexia and dyspraxia was discussed. | |

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

Management of people with long term conditions

Findings

- As part of our inspection, we conducted a series of searches to assess the practice's procedures for the management of patients with long-term conditions. A review of the searches was undertaken by the CQC GP specialist advisor without visiting the practice. The searches were visible to the practice. Overall, the management of patients with long-term conditions was found to be satisfactory. We highlighted to the practice a small number of patients who had not been

followed-up in line with guidance. For example, we found some patients with hypothyroidism had not had the appropriate blood tests within the previous 18 months. Immediately after the inspection the lead GP reviewed all patients identified from our search and sent evidence that all patients had been reviewed and contacted and offered an appointment for blood testing and monitoring. It was noted that one patient had undertaken blood monitoring in a secondary care setting, but this had not been coded on their clinical system. The Lead GP told us that this had now been rectified.

In addition to our clinical searches, we found:

- 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.
- 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) | 124 | 131 | 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) | 102 | 104 | 98.1% | Met 95% WHO based target |
| The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received | 101 | 104 | 97.1% | Met 95% WHO based target |

| | | | | |
|---|-----|-----|-------|--------------------------|
| Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England) | | | | |
| 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) | 102 | 104 | 98.1% | Met 95% WHO based target |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England) | 133 | 142 | 93.7% | Met 90% minimum |

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 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: 30/09/2021) (Public Health England) | 71.7% | 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) (PHE) | 60.6% | 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) (PHE) | 67.8% | 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) (PHE) | 68.4% | 61.2% | 55.4% | No statistical variation |

Any additional evidence or comments

- The practice was aware that cervical screening outcomes were slightly below the England target. The practice demonstrated recall systems for those eligible for cervical screening. Appointments could be booked in practice core and extended hours as well as local extended access services.
- We saw that the practice had undertaken an audit to ensure that a result was received for each cervical screening sample undertaken by their sample takers.
- The practice actively promoted screening services, including breast and bowel screening.

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 |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> The practice had a schedule of non-clinical and clinical audits, which included prescribing and audits of services such as intrauterine contraception (IUC) and subdermal contraceptive implants. We reviewed an audit of patients with an HbA1c >47mmol/mol with no documented diagnosis of diabetes mellitus. The purpose of the audit was to assess whether patients with a recorded HbA1c >47mmol/mol on their latest blood tests had been identified by the surgery as having a diagnosis of diabetes mellitus and whether there was a documented reason as to why patients had not been coded or diagnosed as having diabetes mellitus. The audit reviewed the records of 69 patients and identified six patients that had not been flagged (8.7%). These patients were reviewed, and appropriate action taken. The practice planned to undertake a re-audit. | |

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 |
| 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: | |
| <ul style="list-style-type: none"> Staff were encouraged and facilitated to complete all required and recommended training. We saw that the practice had a mandatory training and frequency schedule in place for clinical and non-clinical staff. Training included safeguarding children and adults, mental capacity act (MCA), infection prevention and control, basic life support, information governance, fire safety awareness, health and safety, manual handling, sepsis awareness and equality and diversity training. There were systems in place to monitor when mandatory training updates were due. | |

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 |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> Staff explained how they worked closely with other local organisations and healthcare providers to ensure patients received care in a coordinated manner. This included the establishing of close working relationship with health visiting teams and palliative care teams. | |

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 |
| 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: | |
| <ul style="list-style-type: none"> The practice provided social prescribing sessions which helped patients improve their health, wellbeing and social welfare by connecting them to community services. The practice encouraged a culture of self-help and self-management through health and promotional information on their website and social media platform. Patients had access via the practice website to an on-line symptom checker, advice and triage service to access an appointment, where appropriate, with the practice. The practice participated in the Community Pharmacy Consultation Scheme which enabled staff to refer minor ailments to the local pharmacy. | |

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 |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> Clinicians we spoke with understood the requirements of legislation and guidance when considering consent and decision making. We reviewed a selection of patient records and found documented discussions and decisions on DNACPR forms. The practice shared an audit undertaken of DNACPR decisions made within the last 12 months. The audit assessed whether patients coded DNACPR on their electronic records had had a discussion about resuscitation with a clinician and whether copies of DNACPR and ReSPECT forms were saved in patients' electronic records. Staff were aware of the need to request consent to share records in line with General Data Protection Regulation (GDPR) principles. | |

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

| | Y/N/Partial |
|---|-------------|
| Staff understood and respected the personal, cultural, social and religious needs of patients. | Yes |
| Staff displayed understanding and a non-judgemental attitude towards patients. | Yes |
| Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition. | Yes |

National GP Patient Survey results

| Indicator | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------------|
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021) | 91.2% | 89.5% | 89.4% | No statistical variation |
| The percentage of respondents to the GP patient survey who stated that the last time | 91.5% | 88.2% | 88.4% | No statistical variation |

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------------------|
| they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021) | | | | |
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021) | 98.9% | 95.7% | 95.6% | Tending towards variation (positive) |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021) | 72.2% | 83.0% | 83.0% | No statistical variation |

| Question | Y/N |
|---|-----|
| The practice carries out its own patient survey/patient feedback exercises. | Yes |

| Any additional evidence |
|---|
| <ul style="list-style-type: none"> • Due to the COVID-19 pandemic we did not have the opportunity to speak with patients on the day of inspection or collect Care Quality Commission (CQC) comment cards. However, we did review the outcomes of the National GP Patient Survey undertaken between January to March 2021 and the NHS Friends and Family Test (FFT) for the period September 2021 to March 2022. • Feedback from the National GP Patient Survey was above local CCG and England averages for patient experience in relation to the healthcare professional listening to them, treating them with care and concern and involving them in decisions about their care and treatment. • Feedback from FFT text messages based on 331 responses, showed that 88% of patients considered the practice to be very good or good, 6% considered the practice to be neither good or bad and 6% considered the practice to be poor or very poor. Patients who felt the practice were very good or good gave feedback which included that staff were friendly, efficient, pleasant and helpful. |

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

| | Y/N/Partial |
|---|-------------|
| Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given. | Yes |
| Staff helped patients and their carers find further information and access community and advocacy services. | Yes |

National GP Patient Survey results

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021) | 95.6% | 93.3% | 92.9% | No statistical variation |

| | Y/N/Partial |
|---|-------------|
| Interpretation services were available for patients who did not have English as a first language. | Yes |
| Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations. | Yes |
| Information leaflets were available in other languages and in easy read format. | Yes |
| Information about support groups was available on the practice website. | Yes |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> The patient appointment self-check-in system was configured to languages aligned to the patient demographic. The practice captured patient communication needs through the new patient registration card. We saw that the practice website had the functionality to translate to other languages. | |

| Carers | Narrative |
|---|--|
| Percentage and number of carers identified. | <ul style="list-style-type: none"> The practice had identified 173 on their carers register, which was 1.4% of the practice population. |
| How the practice supported carers (including young carers). | <ul style="list-style-type: none"> The practice told us they identified carers at the point of registration and on an on-going basis through clinical consultations. The practice offered extended appointments, influenza vaccination and health checks for carers. Carers had access to a social prescriber available at the practice. Information for carers was available on the practice website and on the practice's social media page. |
| How the practice supported recently bereaved patients. | <ul style="list-style-type: none"> The practice told us that if a family had suffered a bereavement a GP would contact them to offer condolences. The practice told us they would signpost patients to the appropriate bereavement support services. We saw that bereavement information was available on the practice website. |

Privacy and dignity

The practice respected patients' privacy and dignity.

| | Y/N/Partial |
|---|-------------|
| A private room was available if patients were distressed or wanted to discuss sensitive issues. | Yes |
| There were arrangements to ensure confidentiality at the reception desk. | Yes |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> On the day of the inspection we observed confidentiality at the reception desk. We saw the computer on the reception desk was positioned so patients could not view the screen and staff told us patients would be offered a private room to discuss sensitive issues. Staff we spoke with told us they followed the practice's confidentiality policy when discussing patients' treatments. This was to ensure that confidential information was kept private, for example, patient information was never on view and personal smart cards were removed when not in use. We saw that all staff had undertaken data security awareness training as part of the mandatory training schedule. | |

Responsive

Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

| | Y/N/Partial |
|--|-------------|
| The practice understood the needs of its local population and had developed services in response to those needs. | Yes |
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided. | Yes |
| The facilities and premises were appropriate for the services being delivered. | Yes |
| The practice made reasonable adjustments when patients found it hard to access services. | Yes |
| There were arrangements in place for people who need translation services. | Yes |
| The practice complied with the Accessible Information Standard. | Yes |

Practice Opening Times

| Day | Time |
|---|------------|
| Opening times: | |
| Monday | 8am to 6pm |
| Tuesday | 8am to 6pm |
| Wednesday | 8am to 6pm |
| Thursday | 8am to 6pm |
| Friday | 8am to 6pm |
| <ul style="list-style-type: none"> The practice provided pre-bookable extended access appointments from 6.30pm to 8pm on Monday and Thursday evenings. | |

- Patients could access pre-bookable extended access appointments through West Cambs Federation at four locations in the area seven days a week, 365 days of the year. We saw appointments were available between 6.30pm and 8.15 pm Monday to Friday and from 8.30am to 12.15pm on Saturdays and Sundays.
- We saw that information was available on the practice's website and at the practice entrance regarding extended access services in the area.

Further information about how the practice is responding to the needs of their population

- Patients had a named GP who supported them in whatever setting they lived. The practice supported two local nursing homes and provided a weekly 'ward round' which included a combination of on-site and telephone advice.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. The practice had a duty doctor each day who saw urgent patients. The practice had also initiated a system where some appointments were held each day for elderly and vulnerable patients to facilitate access.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

People were able to access care and treatment in a timely way.

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

| | Y/N/Partial |
|--|-------------|
| Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice | Yes |
| The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online) | Yes |
| Patients were able to make appointments in a way which met their needs | Yes |
| There were systems in place to support patients who face communication barriers to access treatment | Yes |
| Patients with most urgent needs had their care and treatment prioritised | Yes |
| There was information available for patients to support them to understand how to access services (including on websites and telephone messages) | Yes |

Explanation of any answers and additional evidence:

- The management team were open and transparent about the challenges of patient access due to the change to their appointments and access model during the COVID-19 pandemic. The practice had previously operated an open clinic where patients, if they wished, could queue and wait to be seen at the surgery. During the pandemic, for patient and staff safety, access to appointments changed to predominantly telephone. At that time, it became apparent that the telephone system could not accommodate the increase in inbound calls. The practice had responded to this through the procurement of a new telephone system which was shortly due to 'go live'. The practice told us that once the new telephone system was operational it planned to assess the impact on telephone access through a patient survey.
- The practice told us there had been some negative patient feedback both through the National GP Patient Survey, the NHS Friends and Family Test (FFT) and direct complaints. We saw that the percentage of respondents to the National GP Patient Survey who responded positively to the overall experience of making an appointment had dropped from 60.81% in March 2020 to 45.28% in March 2021. The practice told us they are constantly reviewing their access model to ensure that patients were able to make an appointment with the most appropriate member of their team. For example, GP, advanced nurse practitioner (ANP), practice nurse, healthcare assistant or social prescriber.
- At the time of our inspection patients were able to book appointments online or by speaking with reception staff. Most appointments were initially a telephone triage, following which face-to-face appointments, including same day and emergency appointments, could be arranged where appropriate. This allowed the practice to determine the most appropriate clinician to assess each patient, as well as to discuss any COVID-19 symptoms the patient may be displaying should be a face-to-face appointment be necessary. We saw from the appointment diary that there was a combination of bookable in advance or on the day appointments. A combination of face-to-face, telephone and video appointments were available. The practice also operated a daily duty doctor system who could manage urgent on the day appointments. In addition, the practice held a selection of appointments each day for vulnerable patients.

National GP Patient Survey results

| Indicator | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------------|
| 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 (01/01/2021 to 31/03/2021) | 46.3% | N/A | 67.6% | Variation (negative) |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021) | 45.3% | 72.6% | 70.6% | Variation (negative) |
| The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021) | 56.8% | 68.6% | 67.0% | No statistical variation |

| Indicator | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------------|
| The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021) | 72.2% | 83.6% | 81.7% | No statistical variation |

Any additional evidence

- The practice was aware that there were negative outliers for getting through to the practice on the telephone and the overall experience of making an appointment on the latest National GP Patient Survey. The practice had reviewed the survey and had taken some actions to address the findings. The survey, undertaken between January to March 2021, represented a small sample of the patient population. We saw that 273 questionnaires were sent out (2.2% of the patient list) and 119 were returned (1% of the patient list).
- The practice had also noted some negative feedback from the NHS Friends and Family (FFT) responses. We saw that 6% of patient response on the FFT (based on 331 responses) indicated that they felt the practice were poor or very poor. Responses included a cancelled appointment, a late appointment and the inability to access a timely appointment.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

| Complaints | |
|--|----|
| Number of complaints (written and verbal) received in the last year. | 25 |
| Number of complaints (written) we examined. | 1 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 1 |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman. | 0 |

| Complaints | Y/N/Partial |
|---|-------------|
| Information about how to complain was readily available. | Yes |
| There was evidence that complaints were used to drive continuous improvement. | Yes |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • There was a complaint policy, which was accessible to staff, written in line with recognised guidance. • Information about how to complain was available for patients, for example, on the practice website. • The practice recorded all written and verbal complaints to ensure all opportunities to learn from feedback was captured. Complaints were discussed in meetings as a standing agenda item. • The practice captured patient feedback in the public domain, for example on social media, as part of their complaints review process. | |

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. | Yes |
| They had identified the actions necessary to address these challenges. | Yes |
| 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: | |
| <ul style="list-style-type: none">• The practice had an experienced leadership team in place, who understood both the local and national challenges to healthcare. Managers explained how they continued to improve and adapt their service to ensure it could continue to provide effective care to their patients. For example, during the COVID-19 pandemic it became apparent that the telephone system could not accommodate the increase in inbound calls. The practice had procured a new telephone system and at the time of the inspection were in the final stages of determining a 'go live' date. The new telephone system would provide more functionality and management data to understand and manage peak call periods.• The practice took a proactive role in succession planning and took steps to ensure recruitment into key roles. The practice hoped to recruit an additional partner to support the current partnership.• The management team were open and honest about the challenges of recruitment and retention in their rural practice in the Fens of Cambridgeshire. The practice had recently lost a practice pharmacist. In collaboration within their primary care network (PCN), the practice hoped to engage some staff through the Additional Roles Reimbursement Scheme (ARRS) to improve patient experience and availability of local services. For example, physiotherapist, pharmacy technician, pharmacist and health coach.• The practice was responsive and proactive to feedback during the inspection process and acted immediately upon findings. For example, patients identified as part of our clinical search for further management were immediately reviewed. The management team told us they would use to clinical searches as part of their audit processes. | |

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 |
| Progress against delivery of the strategy was monitored. | Yes |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> We saw that the practice mission statement was 'we are committed to ensuring our patients and staff live happy, healthy lives.' The practice told us this was underpinned by their core values of openness, fairness, respect and accountability. | |

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 |
| 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: | |
| <ul style="list-style-type: none"> There was strong collaboration, team-working and support across all staff and a common focus on improving the quality and sustainability of care and people's experiences. Staff enjoyed working at the practice and spoke highly of the culture. Staff at all levels were encouraged to speak up and raise concerns. Staff we spoke with knew who the nominated freedom to speak up guardian was and how to seek advice and support. | |

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

| Source | Feedback |
|----------------|--|
| Staff Feedback | <p>Feedback from staff who worked for the practice was positive. Staff reported a good working environment and a positive culture. Staff described leaders and managers as approachable and supportive, and felt comfortable in raising any concerns without fear of retribution.</p> <p>Staff acknowledged it had been a difficult time during the pandemic with limited interaction within teams in the building to maintain staff and patient safety. Staff felt happy within their teams but looked forward to a time when interaction, both in and out of work, could resume.</p> |

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 |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> The practice had an established governance process in place. This included partnership and management meetings, monthly practice meetings, attended by all staff and department meetings. For example, nursing and administration. The practice had nominated clinical leads for key areas, such as the safeguarding of adults and children and infection control, whom staff could contact for specialist advice and support. Staff we spoke with understood their individual roles and responsibilities and knew who to contact if further advice was required. | |

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 |
| 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 |

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 (PPG). | Yes |
| 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 |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> The practice had developed good working relationships with their patients, the wider local community, and other stakeholders. Staff and managers worked to deliver and adapt their service to ensure it continued to meet the needs of their patients. The practice had an active and proactive PPG who had continued to meet virtually during the COVID-19 pandemic. The PPG met every two months and was attended by practice clinicians, management and non-clinical team. The group had six regular patient attendees. The practice told us they were trying to recruit more patients to join the group. We saw from minutes that the group had last met in January 2022. We spoke with the PPG chairperson who told us they were due to launch a PPG social media page to facilitate communication and feedback from patients. The practice felt the PPG was supportive but willing to challenge the practice. They felt the group were important to moving the practice forward to continue to meet the needs of the local population. The practice undertook an annual staff survey and had a staff feedback box which enabled staff to share thoughts and feelings in confidence. Staff told us they could provide feedback through meetings, staff surveys, staff suggestion box and annual appraisal. Staff we spoke with felt they the partnership and management team were approachable. | |

Continuous improvement and innovation

There were 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 |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> The practice had an established and long-standing commitment to education and training. The practice was a teaching and training practice. The practice trained GP registrars from the West Cambs Vocational Training Scheme (VTS). At the time of our inspection there were four GP registrars at the practice. | |

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.
- **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.