

# Care Quality Commission

## Inspection Evidence Table

### Port Isaac The Surgery (1-542459759)

Inspection date: 26 September 2022

Date of data download: 08 September 2022

**Overall rating: Good**

**Safe**

**Rating: Good**

#### Safety systems and processes

**The practice had 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"><li>• Our clinical searches identified a child who was included in the child protection register and had not attended immunisation and specialist appointments. We were unable to see any action or investigation had taken place to review this to ensure the safety of the child. We discussed this the practice who reviewed the patient records and found an incorrect code was allocated to the patient electronic records. This meant they were flagged as being listed on the child protection register incorrectly. The practice was able to demonstrate there had been action taken when the patient was not brought to appointments.</li><li>• The practice had completed a risk assessment for all staff who did not provide care and treatment alone to patients. If there were no issues identified in the risk assessment this meant a DBS check</li></ul>	

Safeguarding	Y/N/Partial
was not carried out for that person prior to employment. This process applied to administration, reception and dispensing staff.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At the time of the inspection, the practice operated a dual system for recruitment checks, with both paper and electronic files. This meant not all information was easily accessible when required.</li> <li>Recruitment was carried out by different members of staff according to the role of the staff member being recruited. This created a barrier to having comprehensive and accessible recruitment checks, as documents were stored in different places. For example, on the day of inspection we were unable to see any documentation for a locum member of staff as the manager who had led their recruitment was away from work.</li> <li>There was limited information to demonstrate how the provider assured themselves applicants for roles were suitable or had the required competency. All staff attended an interview prior to being offered employment where this was discussed, but there was no record of the conducted interview.</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: Port Isaac Surgery 22/12/2021 Bridge Medical Centre 22/12/2021	Partial
There was a fire procedure.	Yes
Date of fire risk assessment: Port Isaac Surgery 5/07/2022 Bridge Medical Centre 11/07/2022	
Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Lone working risk assessments and details of the action to reduce risk had been carried out in June 2022 for both Port Isaac Surgery and Bridge Medical Centre. However, the risk assessment had not considered risks from lone working when staff arrived to open or left and secured the</li> </ul>	

building. There was also no information on how clinical staff would call for assistance when alone with a patient in a clinical area should they need to do so. Where risks had been identified when undertaking the health and safety risk assessments, an action plan was compiled which included which staff member was to action and a date for completion. However, the action plans had not been completed to evidence when the action had been taken. During the inspection we discussed this with staff and found actions were taken but not always recorded as completed.

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were not consistently 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: not available	Partial
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• During our inspection visit we observed the practice was visually clean and free from clutter. An external cleaning company attended the practice daily to carry out cleaning and maintained appropriate records.</li> <li>• A new infection prevention and control (IPC) lead had been identified in July 2021. They had developed tools and systems to carry out audits of Port Isaac Surgery and the branch following the National Standards of Healthcare.</li> <li>• The IPC lead had made contact with the IPC lead at the Integrated Care Board (ICB) for advice and guidance.</li> <li>• The practice had implemented procedures during the COVID-19 pandemic to keep patients and staff safe.</li> <li>• All staff had access to policies and procedures on the providers intranet system and staff were aware of these.</li> <li>• Staff were provided with infection control training and for five members of staff whose records we reviewed, we saw four had completed this.</li> <li>• The infection control lead had accessed a staff workbook which linked to the policies and procedures, to be used as a learning tool.</li> <li>• We requested the infection control audits completed by the previous infection control lead before, during and after the inspection but were not provided with these.</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.	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"><li>• We spoke with GPs who told us the workload had increased during and post the COVID pandemic. This meant they often worked additional hours to ensure all administration tasks were completed and patients received safe care and treatment. This was in addition to the appointments provided to patients.</li><li>• Non clinical staff worked additional hours when required and were able to take time off in lieu or receive payment for the additional hours worked.</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. <sup>1</sup>	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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The Primary Care Network (PCN) which the practice was part of had arranged an external company to summarise patients notes when new patients joined the practice.</li> <li>• The practice was part of a local pilot to test the digitalisation of all patient records. This was still in the planning stage at the time of the inspection.</li> <li>• Our clinical searches had identified 1129 tasks were outstanding some of which were relating to test results. We discussed this with the practice who reviewed the tasks and provided information that these had been actioned but not fully closed. We received assurances that the system and process of closing tasks would be reviewed and addressed with staff. The clinicians operated a 'buddy' system to ensure that when they were away from work a colleague reviewed and action new tasks. The duty GP each day also reviewed newly received results from tests which required immediate action.</li> </ul>	

## Appropriate and safe use of medicines

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

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

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) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.90	0.83	0.82	No statistical variation
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). (01/07/2021 to 30/06/2022) (NHSBSA)	10.0%	9.1%	8.5%	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 (01/01/2022 to 30/06/2022) (NHSBSA)	5.60	5.39	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	138.0‰	151.8‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.67	0.65	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	8.8‰	6.9‰	6.8‰	No statistical variation

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.	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).	Partial

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. <sup>1</sup>	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. <sup>2</sup>	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 and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
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 UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> <li>• Patient Group Directions (PGDs) were made available to staff in paper form. (PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines). All PGDs had been signed by each nurse and authorised by a GP. However, we identified that three out of the five PGDs we reviewed had been signed by nursing staff after the GP had signed to say they had authorised them. This meant the GP had not authorised these nurses to use the PGD. We discussed this with the practice and received assurances the system would be changed to ensure individual nurses were authorised to use the PGD. The practice told us the PGDs would be resigned to demonstrate the GP authorised the named nurses within one week of the inspection date.</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.	Yes
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Yes
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Yes
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Yes
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Yes
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Yes
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Yes
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Yes
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Yes
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Yes
<p>Explanation of any answers and other comments on dispensary services:</p> <ul style="list-style-type: none"> <li>The dispensary accepted repeat prescription requests, delivered and collected prescriptions from local collection points and offered a managed repeat prescription service which meant the patients did not have to order their repeat prescriptions.</li> <li>The practice did not have a system to provide electronic prescriptions. We discussed this with the practice and were assured patients who wished to collect their prescriptions from other dispensaries could, on request, arrange for their prescription to be sent by secure email. We were provided with examples of when this system had been used, such as when a patient was on holiday or for provision of specialist equipment such as stoma.</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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	7
Number of events that required action:	4
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>Systems and processes were followed to identify, investigate and address significant events. Learning was shared with staff to reduce the risk of the event reoccurring.</li> <li>The practice informed patients and offered explanations following a significant event which affected an individual patient. We saw records which demonstrated how an investigation had been conducted and feedback to patients and staff.</li> </ul>	

### Example of significant event recorded and actions by the practice.

Event	Specific action taken
The incorrect medicines were dispensed to a patient	Information shared with staff, process changed to no longer accept repeat medicine requests by telephone.
There was an error made taking bloods from the incorrect patient.	Following an investigation feedback and action to take to reduce the risk of reoccurrence was shared at all staff meetings for awareness.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. <sup>1</sup>	Partial
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice had a system and process for ensuring all staff were made aware of safety alerts and appropriate action taken to reduce the risk to patients. However, while action had been taken to reduce the risks highlighted in recent safety alerts, older safety alerts had not been consistently responded to. For example, we saw that 14 patients remained on combinations of medicines that increased their risk of liver problems. We reviewed the clinical records for five of these patients and there was no record to identify this had been identified and the risk discussed with the patient or alternative treatments considered. We discussed this with the</li> </ul>	

provider following our searches of the patient's clinical records. The provider took immediate action and the pharmacist undertook a search of all patients affected and contacted them to change their medicine and discuss the risks. Evidence was provided to demonstrate this had been completed at the time of the onsite inspection.

## Effective

## Rating: Good

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

### Effective needs assessment, care and treatment

**Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. <sup>1</sup>	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. <sup>2</sup>	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 prioritised care for their most clinically vulnerable patients.	Yes

### Effective care for the practice population

Findings
<ul style="list-style-type: none"><li>• 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.</li><li>• Health checks, including frailty assessments, were offered to patients over 75 years of age.</li><li>• Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.</li><li>• The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.</li><li>• Patients did not have access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. The practice had had a period of time of staff shortage in that two health care assistants had resigned. Two health care assistants had been appointed, one was due to start in October 2022, and part of their role was to include the health checks.</li></ul>

- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. A multi-disciplinary team (MDT) meeting took place each fortnight which was attended by clinicians from the practice, palliative care specialist nurse, community nurses and a social worker. This meant information regarding care and treatment plans could be shared and discussed.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. The practice had developed an online assessment template for patients to complete to assist with their care and treatment. A meeting was held every two months with an external clinician specialising in mental health and clinicians from the practice to discuss care and treatment plans for patients with acute or exacerbated mental health illness.
- Patients with poor mental health, including dementia, were referred to appropriate services. The practice also provided information on the website with links to external organisations for support for patients with mental health illness.

## Management of people with long term conditions

### Findings

- Our clinical searches indicated that some patients with long term conditions and/or on high-risk medicines had not been consistently monitored to ensure their treatment was optimised in line with national guidance:
  - 29 out of 1183 patients (2.45%) prescribed ACE inhibitor or Angiotensin II receptor blocker medicines (medicines used to treat blood pressure or heart conditions) had not had the required monitoring. We reviewed the records for five of these patients identified as potentially at risk. For all five patients there was no evidence of patient harm and the practice had sent one or more reminders to the patient to encourage them to attend for monitoring. We were provided of examples for specific patients where texts had been sent and telephone calls had been made to the patient.
  - Our clinical search identified 11 patients who had a potential missed diagnosis of diabetes. We reviewed the clinical records for five patients and were not able to evidence action had been taken to monitor and/or provide appropriate care and treatment. We discussed this with the practice who provided additional evidence to demonstrate action had been taken to ensure the patients safety. The evidence demonstrated that for four patients, their blood monitoring was within normal limits. Five patients were receiving monitoring and care and treatment from the GP or other clinicians for another long term condition which was deemed to affect their blood sugar levels. One patient had a booked blood test due in the month after the inspection. The remaining patient had not been monitored due to a missed appointment. The practice had taken action to contact the patient
  - We reviewed the clinical records for five patients who identified as having a diagnosis of chronic kidney disease stages 4 or 5. (The five stages of CKD refer to how well your

kidneys are working. Stage 1 -3 early stages with 4-5 the advanced stages of kidney disease.) One patient out of the five had not had the appropriate monitoring. The practice had contacted the patient at intervals to advise them to attend for monitoring. For another patient, their records did not show the practice had identified or contacted the patient to attend for further monitoring. This had been addressed by the practice since the inspection and feedback provided to us on the action taken. The practice carried out searches of patients records to ensure monitoring had taken place and the practice reviewed the system for carrying out these searches.

- 13 out of 393 patients (3.31%) with hypothyroidism had not had thyroid function test (TFT) monitoring within the last 18 months. We reviewed the clinical records for five of these patients and found two patients had been sent reminders to attend the practice for monitoring but had not attended. One patient had last had a TFT in 2020 which had not been within normal range. They last received a prescription for thyroxine in 2022 but there was no record on the clinical notes to demonstrate the patient had been advised to attend the practice for monitoring.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. As part of this review patients completed an assessment template online which was reviewed by the lead nurse for asthma. Patients with deteriorating conditions were advised to make a face to face appointment to see the nurse. 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.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.
- 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. Patients who had an identified raised blood pressure were requested to submit seven days of blood pressure readings electronically. Patients were supported to access blood pressure recording machines when necessary. The practice had purchased blood pressure recording machines which would be placed in the waiting rooms for patients to self-monitor. This meant patients waiting for appointments or visiting the practice could monitor their blood pressure and could identify patients with undiagnosed hypertension.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Adults with newly diagnosed cardio-vascular disease were offered statins. (Statins are a group of medicines that can help lower the level of cholesterol in the blood).

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	59	66	89.4%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	67	71	94.4%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	66	71	93.0%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	68	71	95.8%	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 and Improvement)	96	109	88.1%	Below 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>

### Any additional evidence or comments

- The practice had not met the 90% minimum World Health Organisation (WHO) target for child immunisation for two out of five immunisations, as per the above table. However, we saw evidence the practice had a process in place for following up non-attendance of booked appointments and they actively telephoned parents and carers to encourage the uptake.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	75.7%	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) (UKHSA)	70.8%	69.5%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	73.1%	70.1%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	57.7%	54.9%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Any additional evidence or comments
<ul style="list-style-type: none"> <li>The practice did not meet the 80% England average for cervical cancer screening. We saw evidence of unverified data from the practice, which suggested that the practice's cervical screening was 79% for people aged 25-49 and 81% for people aged 50-64.</li> <li>We saw evidence the practice encouraged uptake by inviting eligible patients by text or letters and displaying posters in the practice.</li> </ul>



## Monitoring care and treatment

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

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

## Any additional evidence or comment

- The practice has been involved in clinical research and at the time of the inspection was partaking in four clinical research studies.
- Ongoing audit was carried out by the practice. For example, the practice had reviewed medication prescribed for patients living with attention deficit hyperactivity disorder (ADHD). The practice had also completed a review of medicines prescribed for patients with cardiac disorders which was conducted with a cardiologist.
- The practice provided a training environment for trainee doctors and trainee GPs, who were required to carry out audits as part of their placement at the practice. Findings from the audits were presented to clinicians and discussed as part of the clinical meetings.

## Effective staffing

The practice was not fully 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.	Partial
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>All staff were provided with an annual appraisal with their line manager. Staff we spoke with told us how they were supported to achieve and progress in their roles. There was not a formalised process for one to one sessions between staff and their managers. However, staff told us everyone made time for support and/or supervision when requested. Clinical supervision was arranged and provided when requested and during meetings.</li> <li>The practice had recently changed training provider following feedback from staff and managers. Staff made positive comments about the new system. The practice were not able to provide an oversight of the training of all staff but were able to review individual training records. A training matrix was being collated at the time of the inspection to identify any gaps to enable planning and allocating time to staff to complete their mandatory training.</li> <li>Due to the COVID pandemic some face to face training had not been completed. For example, basic life support. A training session was being arranged for this training with an external organisation in October 2022. This delay had meant that one nonclinical member of staff had not completed basic life support training since employment at the practice.</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.	Yes
Patients received consistent, coordinated, person-centered care when they moved between services.	Yes



## Helping patients to live healthier lives

### Staff were 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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Online assessment templates were used to assist clinicians to assess and provide guidance for healthier lifestyles. For example, stopping smoking, reducing alcohol consumption, weight management and exercise.</li> <li>• The practice had experienced periods of staffing shortages and this had impacted on annual health checks for patients aged 40 to 75. Additional staff had been recruited and a plan made to restart the health checks once the staff were in post and had completed their induction training.</li> </ul>	

## 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. <sup>1</sup>	Yes
<ul style="list-style-type: none"> <li>• Our clinical review of notes where a DNACPR decision had been recorded, identified that, where possible, the patient's views had been sought and respected.</li> </ul>	

## Responsive

Rating: Not rated

Port Isaac The Surgery was rated Good for the provision of Responsive services as a result of our inspection in 23 January 2019. In accordance with Care Quality Commission methodology, the ratings from our previous inspection for this key questions (caring) have been carried through to contribute to the overall rating for the practice.

### 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 and Improvement 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 (including those who might be digitally excluded).	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
<ul style="list-style-type: none"><li>• All patients were required to complete an online request form when they required a consultation with a health professional. For patients who were unable to access the internet to complete the form, reception staff would support them on the telephone.</li><li>• The online consultation request was triaged by a clinician and allocated to the most appropriate clinician for either a telephone or face to face consultation or a home visit. Once the clinician had triaged the patient, they were able to book them an appointment while on the phone with the patient if required.</li><li>• The practice operated a duty GP system which meant a GP was available at each session to provide telephone calls and face to face for patients and support to colleagues.</li><li>• On the day of our inspection there were appointments available for face to face and telephone consultations for the same day and the next day. Patients were also able to pre book appointments in advance using the same system.</li><li>• The practice had listened to feedback from patients regarding the initial online consultation system used when they reported it was time consuming and not specific to the symptom highlighted. The</li></ul>	

practice changed the system and the current system used provided more specific options for patients to highlight their symptoms or reason for contacting the practice.

## Well-led

## Rating: Requires Improvement

### 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"><li>Staff were supported to develop within their roles and move into other roles.</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.	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

### 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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>All staff we spoke with were positive about working at the practice and the support they received from their colleagues. Training records were both electronic and paper. The practice had recently changed training providers and an overview of the staff teams training was not available. The practice manager was in the process of updating and reviewing oversight of the training. We looked at the personnel records of five members of staff and the evidence available showed only one of those members of staff had completed equality and diversity training. However, the practice was compiling a training matrix which would provide full oversight of staff training and staff would be advised to complete any outstanding training.</li> </ul>	

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

Source	Feedback
CQC questionnaires Conversations with staff	<ul style="list-style-type: none"> <li>Staff described working at the practice as the best place they had worked with positive comments made about the teamwork amongst all staff.</li> <li>All staff we spoke with felt supported and listened to. They were able to make suggestions for improvement or raise concerns.</li> </ul>

#### Governance arrangements

**There were not consistent and 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.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
<ul style="list-style-type: none"> <li>The practice had implemented governance systems. However, there had not been consistent oversight to ensure the systems and processes had been followed to promote safety. For example, the system for registered health professionals to administer specified medicines so that all nurses are consistently approved by the nominated person.</li> <li>There had been insufficient oversight of patients and/or their clinical records, who required additional monitoring due to their medicines or conditions.</li> </ul>	



## Managing risks, issues and performance

**There were processes for managing risks, issues and performance which had not been consistently managed.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• While there were systems and processes to reduce risk, not all had been followed consistently, and records were not accessible at all times.</li> <li>• For example, the recruitment records were incomplete or not accessible at all times for a number of staff.</li> <li>• Staff training records were not fully accessible on the day of the inspection which meant there were not full records to demonstrate all of the completed staff training.</li> <li>• Safety alerts had not been consistently actioned appropriately.</li> <li>• Records relating to infection prevention and control audits and associated actions were not available within the practice.</li> <li>• Risk assessments relating to lone working had not considered all of the risks staff faced. Associated action plans had not been completed to demonstrate action had been taken to reduce the risk.</li> </ul>	

## 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
Explanation of any answers and additional evidence: Where areas for improvement were identified by CQC the practice were active in addressing these.	

## 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
Staff are supported to work remotely where applicable.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>During the COVID pandemic some staff were supported to work from home. Agreements were made with staff regarding the use of laptops and security of records.</li> </ul>	

## 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.	No
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"> <li>• The practice was committed to seeking feedback from and engaging with the patients. A friends and family test survey and collection box was clearly visible in the waiting rooms.</li> <li>• The practice did not have an active Patient Participation Group (PPG). The practice advertised the benefits of this and information on how to join on the information screens in the waiting rooms. Despite this there had not been any interested parties.</li> <li>• The practice had a planned programme for staff meetings. For example, clinical meetings were held every fortnight, multi-disciplinary meetings each month and administrator / receptionist meetings each month. These meetings provided the opportunity to share and receive information from teams of staff.</li> </ul>	

Feedback from Patient Participation Group.

Feedback
As the practice did not have a PPG we were unable to collect feedback from them. The practice listened to patient voice via other sources identified above.

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes

Examples of continuous learning and improvement
<ul style="list-style-type: none"> <li>• The practice had a programme for training and learning following on from meetings. Staff were able to suggest topics to discuss and a presentation was prepared by a member of staff or an external person. For example, a recent training session had been delivered regarding hypertension (high blood pressure).</li> </ul>

- Staff we spoke with felt confident to identify and implement areas of improvement. For example, the dispensary staff had introduced a new storage system for prepared medicines to ensure confidentiality.

## 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.
- **UKHSA:** UK Health and Security Agency.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ‰ = per thousand.