

Care Quality Commission

Inspection Evidence Table

Newquay Health Centre (1-540339214)

Inspection date: 25 November 2022

Date of data download: 01 February 2023

Overall rating: Good

At our previous inspection in December 2021, we rated the practice as Requires Improvement. This was because assessments of risks to the health and safety of service users were not being carried out, including fire safety. There was a lack of assessment of risk and audit to infection prevention and control (IPC). The practice had not ensured all information was obtained upon recruitment of staff in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities).

At this inspection in November 2022, we rated the location as Good overall due to improvements being made in all areas of previous non-compliance.

Safe

Rating: Good

At our previous inspection in December 2021, we rated the practice as Requires Improvement for providing safe services because:

- Staff recruitment records were incomplete or not up to date.
- There was no evidence of infection prevention and control (IPC) risk assessment or audits being carried out since 2019.
- The practice did not have a reliable system in place to ensure the security and tracking of blank prescriptions and this was not in line with national guidance.
- Annual appraisals and clinical supervision had not been carried out routinely or recorded formally due to the disruption caused by the COVID-19 pandemic.

At this inspection in November 2022, we rated the practice as Good for providing safe services. We found:

- Improvements had been made to ensure safe recruitment was in place and records were kept up to date.
- The practice had made improvements to the infection prevention and control (IPC) systems and processes in place, including completing audits and a risk assessment.
- Practice arrangements to identify and mitigate health and safety risks were effective.
- The practice had made improvements in the systems to ensure the security and tracking of blank prescriptions were in line with national guidance.

- Clinical supervision for non-medical prescribers was in place to ensure safe prescribing was provided and within scope of practice. However, there was a lack of formal standard operating procedures to give guidance for staff.

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"> • There was a safeguarding system and policy for vulnerable adults and children which was review in November 2022. There were local arrangements and key contacts for making safeguarding referrals. • Fifteen staff responded in a Care Quality Commission (CQC) survey. Their comments demonstrated they had received appropriate training, understood how to identify and report any suspected abuse of children and/or adults. • Two GP partners provided leadership for all safeguarding matters at the practice. This included leading multidisciplinary meetings and representing the practice at wider safeguarding meetings in Cornwall. • Non-clinical staff verified that they were never asked to perform chaperone duties. We were told only clinical staff were approached to do this and all had a Disclosure and Barring Service (DBS) check undertaken. A DBS check is used to the assess a criminal record for someone applying for a job role. • The practice had a system to identify vulnerable patients on record and there were regular discussions between the practice and other community care professionals such as health visitors, social workers and support from the Primary Care Network (PCN). 	

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

Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>After the last inspection, the practice sent CQC an action plan outlining how improvements would be made in relation to gaps seen in recruitment procedures. At this inspection, we found evidence demonstrating improvement with recruitment systems, for example:</p> <ul style="list-style-type: none"> We sampled two staff files and found appropriate checks, including DBS and professional registration, were obtained prior to commencement of employment of a clinical member of staff. Health information, including staff vaccination status were now held on record. The practice held a register of regular locum GPs and Nurses employed to provide absence and annual leave cover. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 24 May 2022	Yes
There was a fire procedure. Date of fire risk assessment: 21 June 2022	Yes
Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At this inspection, we found improvements with all aspects of health and safety. For example, risk assessments were in place, actioned and up to date. We obtained evidence and found:</p> <ul style="list-style-type: none"> The practice now had an electrical safety risk assessment in place. Touring the building, we did not observe any hazards during the inspection. Fire training, drills and alarm testing had been delivered regularly as per fire safety policy. The fire risk assessment completed in June 2022 deemed the premises as non-compliant. All critical and major non-compliance actions had been completed by the practice. Interim arrangements were in place for minor outstanding actions to reduce risk. For example, the premises external exit route was positioned by building renovation work. The practice had put up a barrier to reduce the risk of falls for people exiting the building. The practice had completed a Control of Substances Hazardous to Health (COSHH) risk assessment and we saw evidence of measures taken to reduce any associated risks to service users and staff. For example, we observed medical oxygen cylinders stored appropriately in line with the practice risk assessment, completed in May 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.	Yes

Date of last infection prevention and control audit:	
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:	
<p>At the last inspection, we found gaps in infection prevention and control (IPC) systems. The practice sent us an action plan. At this inspection, we saw evidence demonstrating improvement across all IPC systems, for example:</p> <ul style="list-style-type: none"> • The practice had reviewed and updated the IPC policy to meet current requirements as per Department of Health guidelines. • Fifteen staff responding in a CQC survey were able to identify the named clinical leads responsible for IPC management. • We spoke with one of the staff responsible for IPC who confirmed audits, including monthly hygiene audits, were resumed following the last inspection and regularly undertaken in line with provider policy. Equipment used for training staff with hand hygiene had been purchased and was being used when audits were done. • We looked at the most recent hand hygiene audit carried out on 15 November 2022 demonstrating assurance of effective IPC practice was followed by staff. • In 15 staff surveys, staff confirmed they received mandatory training at the practice, including IPC training every three years. • The practice had commissioned an independent consultant to carry out a legionella risk assessment on 19 April 2022. The water system was checked and no concerns were raised in the report that followed the assessment. 	

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:	
<p>The practice demonstrated there were adequate systems to assess, monitor and manage risks to patient safety. Examples seen included:</p>	

- The practice had identified risks associated with staffing issues and demonstrated actions taken to reduce these. For example, locum GPs were used to cover sessions where needed. Staff had suggested they could also provide additional cover and a new contact system was set up for this purpose via an encrypted service. Staff reported they could now respond quickly to any requests for cover, which had improved patient access.
- In a CQC survey, staff verified staffing levels were able to meet patient demands. Staff highlighted patient demand had increased significantly over the last 12 months and steps were taken wherever possible to increase resources to meet this.
- We interviewed a patient representative, who told us the practice openly shared concerns around recruitment and succession planning set against national shortages of GPs and practice nurses.
- The practice had successfully increased clinical input and now had a mental health specialist providing appointments 1.5 days per week. A new advanced nurse practitioner and a newly qualified nurse were recently employed to increase the nursing team resource.
- The training matrix demonstrated staff received appropriate training enabling them to identify if a patient's health was deteriorating and needed immediate referral to the duty GP.
- Fifteen staff responses to the CQC survey verified there was a written pathway, which was accessible for all reception and administrative staff providing guidance of when to escalate concerns to clinical staff.
- Since the last inspection, the practice had introduced a new assessment system to improve patient access. This could be completed online by a patient or with assistance from reception staff. The assessment form automatically prompted the patient and/or staff when to dial 999 as an emergency, or if urgent assessment was required in practice.
- Clinical staff used nationally recognised tools to assess patient needs, for example identifying symptoms of suspected sepsis.
- All staff had recently completed a Basic Life Support update, and where appropriate for clinicians anaphylaxis training.

Information to deliver safe care and treatment

Staff had 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. ¹	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence:	

- During this inspection, we conducted a review of patient records with the practice's clinical record system and identified records were managed to ensure patients received safe care and treatment. Records contained relevant, accurate and up to date information in line with current guidance.
- There was a dedicated administration team of staff who were responsible for ensuring urgent and routine patient referrals were actioned and followed up. For urgent referrals, there was a system for staff to check patients had attended their appointment.
- Senior clinical staff told us the practice had altered the arrangements for reviewing pathology results since we last inspected. The practice had a 'buddy' system to cover clinician absences. There was a dedicated standard operating procedure documenting guidance for staff for reviewing pathology results. However, this did not set out quality indicators and expected timescales in which pathology and blood results should be checked and actioned by a clinician. We were shown the inbox and management of test results. The majority of test results were managed in a timely manner. However, we discussed three patient records with abnormal results received during the previous 10 days which did not have a recorded action. Of these results, one patient was being monitored by secondary care services. This meant there was a risk in the delay of patients receiving safe care and treatment. After the inspection, the provider revised the standard operating procedure so that pathology results guidance prompted clinical staff to include safety netting checks for outstanding results. As this were newly revised, further time was needed for this process to be embedded and demonstrate positive impact to patient outcomes.

Appropriate and safe use of medicines

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

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL 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)	0.89	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)	9.1%	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	5.53	5.39	5.31	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	120.9‰	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) <small>(NHSBSA)</small>	0.78	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) <small>(NHSBSA)</small>	6.5‰	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).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of effective 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 and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes

Medicines management	Y/N/Partial
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 data-bbox="57 533 1541 586">Explanation of any answers and additional evidence, including from clinical searches.</p> <ul data-bbox="108 622 1541 1601" style="list-style-type: none"> • Clinical supervision was given by the practice's lead GP, who provided oversight of performance and nurse prescribing to ensure this was within scope of practice. Audits and conversations were recorded but there was no formal standard operating procedure outlining supervision arrangements and guidance for staff. Therefore, there was a risk that staff would not receive the appropriate guidance to regular timeframes. • The practice had a process to manage information changes to medicines prescribed to patients, including changes made by other services, for example, the out of hours provider (OOH). • During this inspection, we undertook remote searches of the practice's clinical records system. From our search findings, we determined that there was a system in place to ensure patients who had been prescribed high-risk medicines had been appropriately monitored and reviewed, in line with National Institute for Health and Care Excellence (NICE) guidelines. • We reviewed a sample of five medicine reviews and found these were recorded appropriately, documenting patient outcomes and addressed the required monitoring or changes to treatment. • There was a process for Controlled Drugs (CDs) disposal. We saw evidence of an audited CD log. CDs were stored in a locked cupboard, the keys were kept securely in a designated place. There was a set procedure for the dispensing of Controlled Drugs to patients. • Emergency medicines were stored on a crash trolley, accessible to appropriate staff. There also was a stock of medicines within a locked cupboard. We saw evidence of regular stock checks including a review of expiry dates. Medicines had been risk assessed to ensure appropriate medicines were included. Medical equipment included a defibrillator and oxygen cylinders, with a service agreement for replacements when oxygen levels were low or expired. • There was a process in place for managing cold chain protocol to ensure medicines which required storage at certain temperatures were stored in line with manufacturers' guidelines. We observed fridge temperature logs which were checked daily to ensure medicines were stored appropriately. 	

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:	40
Number of events that required action:	28
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff we spoke to verified the practice had processes to manage incidents, concerns and near misses. Staff were clear on their roles to raise safety incidents and how to report concerns appropriately. The practice was able to demonstrate learning and the dissemination of information relating to significant events. Following a significant event, the practice advised the event was investigated, learning from the event was identified and shared at multi-disciplinary team meetings. Formal minutes were recorded and shared to staff via email correspondence. 	

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

Event	Specific action taken
An incident occurred where a two-week wait (2ww) referral was delayed. (A 2ww referral is an urgent appointment request raised from the GP Practice to the local hospital due to the possible symptoms of cancer).	The incident was reviewed openly and transparently. The patient was contacted and an apology was provided in line with the duty of candour. The practice revised its 2ww standard operating procedures and updated the clinical system to alert staff using the task management system to ensure future urgent referrals were not delayed as a safety netting mechanism. Learning was shared with staff in a significant event meeting to minimise the risk of reoccurrence.
An incident occurred where a duplicate repeat medicine request for a patient was authorised by the practice.	The incident was investigated to find the root cause. The patient was informed there were options to raise prescription requests. The practice had reviewed medicine management procedures and shared learning with staff to raise awareness for greater care when authorising repeat medicines, to minimise the risk of reoccurrence.

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"> There was a safety alerts policy that outlined the procedure with guidelines for actions to take when receiving alerts. The lead GP and practice manager held administrative oversight and shared actions taken in relation to the each alert with the clinical team on a monthly basis. We saw evidence of actions taken in response to a safety alert published in 2018 and later updated in 2021, regarding sodium valproate (a medicine used to treat epilepsy and bipolar disorder) with associated actions such as discussions with female patients prescribed this medicine about potential risks during pregnancy to unborn children. We reviewed a sample of five patient records and found there had been a documented discussion review with all patients, who were informed about the risks, to ensure safe care and treatment. 	

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. ¹	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated. ³	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
Explanation of any answers and additional evidence: The practice demonstrated it delivered effective assessment and treatment of patient needs. Examples seen were: <ul style="list-style-type: none">• Standard assessment templates were used providing assurance that a consistent approach to assessment and documentation of needs and treatment.• Patient records sampled following CQC searches demonstrated all patients were followed up in a timely way.• Fifteen staff responses to the CQC survey confirmed they understood their duties in regard to accessibility requirements for patients and staff. For example, clinical codes were applied on the practice system highlighting whether patients were deaf, hard of hearing, visually impaired, or had a physical or learning disability to ensure patient needs were met.	

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.
- A named GP was linked to each adult social care home, promoting continuity of care of patients residing there.
- 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.
- The practice held patient registers to monitor and recall specific patients for review. For example, all 73 patients with a learning disability were offered and completed an annual health check in the last 12 months.
- 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. A GP was a GPwSI (GP with Special Interest - addictions) who took the lead for following up and supporting people with addiction and/or in recovery.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. People had access to a mental health nurse specialist 1.5 days per week at the practice.

Management of people with long term conditions

Findings

Explanation of any answers and additional evidence:

- We conducted remote searches on the practice's clinical records system and found that patients who required monitoring of long-term conditions were followed up appropriately in line with national guidelines. Accurate records were kept and coded effectively.
- Patients with long-term conditions were offered an effective 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 and the Primary Care Network's (PCN) pharmacist followed up patients who had received treatment in hospital or through out of hours services following acute exacerbations 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 undergoing further review of their treatment, following the recruitment of a respiratory nurse specialist, and offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	124	138	89.9%	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)	174	192	90.6%	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)	174	192	90.6%	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)	174	192	90.6%	Met 90% minimum
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)	165	185	89.2%	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

- Clinical staff we spoke with were aware of the practice's initiative to provide further education to assist young families in the importance of these immunisations. For example, the practice had plans in place to hold additional childhood and baby immunisation health sessions, to be held every Saturday as part of extended access arrangements, to improve uptake.

- The practice monitored Did Not Attend (DNA) appointments with appropriate follow-up processes to ensure children were safeguarded from potential abuse or neglect.

Cancer Indicators	Practice	SICBL 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: 30/06/2022) (UK Health and Security Agency)	74.2%	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)	66.6%	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)	69.4%	70.1%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	40.2%	55.2%	54.9%	Tending towards variation (negative)

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Any additional evidence or comments

- The practice had a slightly increased uptake of eligible women having cervical cancer screening (previously at 73.6%) since the last inspection. The practice population comprises of high levels of deprivation, the practice continued to work to improve healthcare for vulnerable people in the area through providing educational information within the surgery and on the website.
- A GP partner with special interest in reproductive health had oversight of the uptake of eligible women for cervical screening. Additional appointments focusing on women's reproductive health, including contraception and cervical screening were held on Saturdays during the last 12 months. We were unable to verify more up to date information provided by the practice in this area.
- Nursing staff had undertaken additional training to raise their awareness of perimenopause and menopause experienced by older women. The practice was focused on improving their experiences, for example of cervical screening, by proactively offering hormone creams ahead of this procedure to reduce discomfort they might experience.

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

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

Any additional evidence or comments
<ul style="list-style-type: none"> The practice had a comprehensive quality improvement program which was reviewed throughout the year by the clinical team, with findings discussed at clinical meetings. For example: The provider completed a post-procedural infection rate audit in patients who had undergone minor operations for skin cancer diagnosis between January 2022 and December 2022. There was a total of 4 patient infections over 208 operations performed, highlighting an infection rate of 0.02%. This is below the benchmarked surgical infection rate of 5% for dermatology procedures as published by National Institute for Care Excellence (NICE). The provider completed a dermoscopy audit between July and December 2021 to assess skin cancer diagnosis for patients using skin surface microscopy prior to referrals to secondary care. 53 skin lesions were assessed, of which, nine two-week wait referrals (2ww) were completed. This equated to a referral conversion rate of 60%. A conversion rate is defined as referrals that were appropriate. None of the conditions not referred had re-presented as of June 2022, when reviewed. This was compared with non-dermoscopically assessed lesions by other GPs, during that period. 189 skin lesions were assessed, of which, 68 2ww referrals were completed. This equated to a referral conversion rate of 36%. The dermoscopy service provided was dependable for the time period analysed and shown to decrease the number of unnecessary referrals to secondary care. Cervical screening audits were carried out monthly by qualified clinical staff. This provided continued assurance that samples were accurately taken, repeated where necessary and abnormal results followed-up appropriately. Further training opportunities were available for clinical staff to ensure competencies were maintained in this area.

Effective staffing

The practice was able to demonstrate 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Staff training deemed mandatory by the practice training policy was completed and up to date. There was a system in place to ensure records were checked regularly. <p>Since the last inspection, the practice had recently recruited two new clinical staff:</p> <ul style="list-style-type: none"> An advanced nurse practitioner, who was a non-medical prescriber, had recently started working at the practice and was providing additional appointments for patients. Supervising GP partners verified they recorded and met regularly with clinical staff holding advanced clinical practice qualifications. However, this was not set out in a formal written agreement, for example covering ongoing assessment of prescribing competency and scope of clinical practice. A salaried GP had recently started working at the practice and had an induction. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had a system to manage communication between services about patients so they received consistent and co-ordinated care. For example, meetings took place between the local out of hours service and the provider for the safe handover of clinical records and treatment plans of patients moving between the services. 	

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	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

Consent to care and treatment

The practice always obtained to demonstrate that it 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">During a review of clinical records, we identified consent and decision making was recorded in line with legislation and guidance.Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms were in place for patients when needed. We reviewed three of these forms and found they had been completed with patient involvement and reviews had been done in line with guidance. Recommended Summary Plan for Emergency Care and Treatment (RESPECT) forms, to record patient's wishes on treatment received and whether they wanted to be admitted to hospital, were used for end of life patients where appropriate.	

Responsive

Rating: Good

The data and evidence we reviewed in relation to the responsive key question as part of this inspection did not suggest we needed to review the rating for responsive at this time. Responsive remains rated as Good.

Access to the service

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

	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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• In the GP Survey, 88% patients were satisfied with the appointments or appointments offered which was trending towards a positive variation in comparison with local and national averages (national average of 73%).• Since the last inspection, the process of making an appointment had been reviewed. All patients now completed a form either online or at the practice, which was triaged by a GP and a decision was made whether the patient needed a same day or routine appointment, the patient was then assigned to an appropriate clinician.• Reasonable adjustments such as extended appointments were available when required. Continuity of care was also considered when appointments were requested.• Home visit appointments were available for frail or vulnerable patients and those who were too ill to attend the practice. The duty GP was supported by a home visiting paramedic.• Pre-bookable appointments were available up to two weeks in advance.• The practice had completed an analysis of access report data in November 2022 comprised of volume of patient appointment requests through telephone, in person or online by date and inbound telephone call data by date and time. Patient feedback gathered by the practice between October and November 2022 showed out of 908 patients, 727 (80%) had rated the appointment system as 'good' or 'excellent' in relation to satisfaction of timely access to appointments.	

Well-led

Rating: Good

At the inspection in December 2021, we rated the practice as Requires Improvement for providing well-led services because:

- Recent actions implemented by the senior leadership team provided some assurance of the provider's oversight of risks and awareness of key issues requiring improvement. However, due to the team being newly re-organised in its current iteration they needed time to demonstrate a clear understanding of accountabilities and new processes were embedded with lasting improvements.
- Clinical governance systems, including oversight of medicines management specifically security of blank prescription stationary, adherence to recruitment and induction procedures and health and safety risk assessments were not fully effective due to the fact they needed further time to fully embed.
- Staffing at Newquay Health Centre was potentially vulnerable due to the impact of staff shortages, unexpected absences and recruitment challenges.
- People did not always receive a timely apology when something went wrong and were not consistently told about any actions taken to improve processes to prevent the same happening again.

At this inspection, we found improvements in all of these areas. The practice is therefore now rated **Good** for providing **well-led** services.

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

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:	

- There was a mission statement displayed on the practice's website which staff were aware of. Staff said they were proud to work for the practice and there was support available to carry out their roles.
- The practice had a set of values developed in collaboration with staff underpinning the overall mission statement.
- In response to a CQC survey, staff demonstrated there was a shared vision which was founded on patient centred care.

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"> • The incident reporting system complied with the requirements of the duty of candour. • The practice had a senior manager who provided oversight for investigating and responding to complaints received across both sites. The practice now had a complaints policy in place which included information for response timeframes. • The practice had an open and transparent approach to complaints. Investigations were conducted by relevant staff. Outcomes from investigations were shared at team meetings and with individual staff as needed. • We reviewed two samples of complaints between January and November 2022: • A temporary patient was registered as permanent by mistake during the holiday season. The practice had investigated to find the root-cause, human error, and the patient was contacted with an apology within policy timeframes. The patient was able to re-register with their normal GP practice and the patient was happy with the outcome. • There was an incident that occurred regarding a patient prescribed antidepressant medicines instead of hormone replacement therapy (HRT). The practice reviewed the patient's medical records to assess the monitoring and care which had taken place within secondary care. The patient was contacted in line with the duty of candour. The practice had since developed a dedicated prescribing policy for these medicines to ensure guidance was available to staff in relation to blood monitoring and prescribing. Learning was shared with all clinical staff to minimise the risk of reoccurrence. 	

- Staff were able to speak up openly if they had any concerns and the working environment was friendly and supportive. Staff had access to a freedom to speak up guardian and a mental health first aider.
- The practice had a whistleblowing procedure available for staff to access electronically and in paper format at the practice.

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

Source	Feedback
CQC Staff Survey	15 staff responding in a survey told us they were proud to work at the practice and were focused on the needs of their patients. There were themes around increased patient demand. All of the staff which had responded, highlighted they felt the provider was responsive and made changes to improve staff well-being and secured additional resources where possible.

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
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had improved its arrangements for governance and performance management. Evidence seen throughout the inspection demonstrated the practice now had a written framework which all staff understood and followed. For example: • Staff recruitment records now provided assurance of safe appointments being made in line with legislation. • New systems were well implemented, staff had been fully trained and were well informed with all new policies and procedures. • Systems and processes were now place to ensure effective oversight of complaints. • Health and safety requirements were being adhered to, for example risk assessments demonstrating mitigation and actions taken were now overseen by a lead member of staff. • Governance and performance was now a standing agenda item at practice meetings, where partners reviewed information and made decisions accordingly. 	

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
<p>Explanation of any answers and additional evidence:</p> <p>The practice now had effective systems to manage risks, issues and performance:</p> <ul style="list-style-type: none"> The practice now had fully embedded systems and processes to keep patients safe. For example, changes had been implemented to provide assurance of the safe management of medicines and staff recruitment records evidenced all appropriate pre-employment checks were undertaken. Potential health and safety risks were assessed and there were monitoring systems in place overseen by named staff. Reports to the GP partners and practice manager were monitored at practice meetings and via the practice record system. The provider evidenced assurance that infection prevention and control (IPC) measures were effective. Staffing resources had increased since the last inspection. The practice had an ongoing succession plan in place. <p>Quality improvement initiatives were now embedded at the practice:</p> <ul style="list-style-type: none"> Standard operating procedures were now accessible on a new records system, regularly monitored and updated. For example, IPC was in line with national guidelines. The practice continued to work with other practices to promote ongoing sustainability of quality of care including utilising shared resources across its membership of the Primary Care Network. The provider introduced a multidisciplinary staffing model and access to other professionals through this (such as clinical pharmacists, physiotherapist and paramedics) to benefit the patient population. The staff understood the needs of patients, had prioritised and chosen to continue to deliver some health promotion checks for vulnerable people that could have been paused as per national guidelines. 	

- There was a high prevalence of substance misuse and high levels of deprivation in Newquay. The practice had a lead GP with specialist interest in this area who was working with third sector agencies to develop healthcare services for vulnerable people in the area.
- The practice population was significantly increasing, with further local population projected growth of 20,000 – 30,000 predicted in the next five years. The practice had applied for funding for a new build to accommodate the increasing healthcare needs of the community. A decision about this was imminent when we inspected. The development project approved by the local commissioners will include opportunities to expand clinical, educational and administrative services.
- The national clinical staffing crisis continued to impact recruitment in the area. However, links with academic establishments were in place supporting the placements for GP registrars, nurses, emergency care practitioners into the practice.
- The practice continued to use a small number of regular locum GPs.

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:	
<ul style="list-style-type: none"> • The practice had not needed to make any statutory notifications to relevant organisations such as the Care Quality Commission (CQC) or National Health Service England (NHSE) within the last 12 months. However, members of the leadership team were aware of their responsibilities to do so if a notification was required. 	

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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Patient data and information was stored securely in line with digital security standards with relevant information was made available for patients to access in line with privacy, consent notices and general data protection regulations. 	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
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 an active Patient Participation Group (PPG), which met with key staff members at the practice, quarterly. Areas discussed included, patient access to community services, staffing capacity, patient feedback and practice website improvements. 	

- The practice actively encouraged feedback about the services provided through the completion of the Friends and Families Test survey, the practice website and discussions with the PPG.
- The practice held oversight of patient feedback responses and themes through the 'Friends and Families Test' survey. For example, the practice had reviewed the feedback completed within November 2022. The practice identified out of 13,277 total patient appointments, 173 patients gave feedback, a response rate of 1.5%. Of those 173 patient feedback submissions, 94% of responses were positive and recommended the service and care given by health care professionals to their friends and family.

Feedback from Patient Participation Group.

Feedback

- We spoke with a representative from the Patient Participation Group (PPG) who told us that the practice had made changes based on patient feedback. The practice had piloted a new 'Kilnik' system to assist with digital triage and improved patient access.

Any additional evidence

- From the national GP Patient Survey, conducted between January and March 2022, 82% of patients at the practice were satisfied with the overall experience (compared to a national average of 72%).

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice provided placements for GP registrars training to be qualified GPs, trainee doctors and medical students. • Newquay Health Centre had an established research team comprising of a two research GPs and two research nurses undertaking a mixture of commercial and non-commercial research. The research team worked collaboratively with the NHS and one of the GPs had become the head of the Cornwall Research Network. • The lead GP focused on providing community education sessions based on preventative health. For example, a workshop had been held in local schools, which had taught students about clean air health and asthma management. • The provider had been recognised with the 'Green impact gold award' in line with striving towards NHS targets for reducing organisational carbon footprint to net zero. 	

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > 1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a SICBL 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 SICBL 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.