

Care Quality Commission

Inspection Evidence Table

The Clays Practice (1-549804414)

Inspection date: 9 June 2022

Date of data download: 07 June 2022

Overall rating: Requires Improvement

There was a lack of process in place for monitoring patients' health in relation to the use of medicines including high risk medicines with appropriate monitoring and clinical review prior to prescribing. This included ensuring all patients received an annual review of their medicines.

Effective systems and processes to ensure good governance were not in place.

We found that the practice had made some improvements, although some areas of work remained ongoing, and it was therefore rated as requires improvement overall.

Safe

Rating: Requires Improvement

Systems and processes relating to safety, including infection prevention and control and responding to patient safety alerts, were not developed and implemented in a way that kept people safe.

The provider did not have clear safeguarding processes in place to keep patients safe. Not all staff were up to date with the appropriate level of safeguarding training for their role and safeguarding meetings were currently not being held.

Processes to ensure medicines requiring refrigeration had been stored in line with the manufacturers' guidelines were not in place.

Recruitment processes were not always safe, some pre-employment checks had not been undertaken.

Safety systems and processes

The practice did not have 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.	Partial
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes

Safeguarding	Y/N/Partial
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in September 2021, the practice's safeguarding children policy had not been reviewed at the date specified and did not identify who was the safeguarding children lead in the practice. We reviewed the policy updated in May 2022, this policy stated what levels of safeguarding children and safeguarding adults training staff needed to complete and how frequently staff needed to do the training.</p> <p>At our previous inspection, we found that, out of 51 staff, 16 were overdue training in safeguarding children and 14 were overdue training in safeguarding adults.</p> <p>At this inspection, out of 50 staff, five had either not received training or were overdue training in safeguarding children and four had either not received training or were overdue training in safeguarding adults.</p> <p>At our previous inspection not all staff had a record of a completed DBS check in place (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).. Records seen for this inspection showed that DBS checks had been completed for 20 staff since our last inspection. However, there was no record of a DBS check having been requested for 11 out of the 53 members of staff. The provider had not completed risk assessments for staff for whom they did not have a DBS check to ensure their suitability for their roles.</p>	

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> <p>At our last inspection, the practice manager had identified shortfalls with the practice's previous recruitment processes.</p> <p>During this inspection, we looked at the personnel files for two members of staff who had started working at the practice since our last inspection. Recruitment checks had been completed in accordance with regulations for one of the staff members. However, there was no evidence of pre-employment recruitment checks, including a DBS check, references and a full employment history including an explanation for any gaps, having been completed for the other, to ensure their suitability for the role.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Yes

Date of last assessment: 22 June 2021	
There was a fire procedure.	Yes
Date of fire risk assessment: The Clays Practice, Roche (Main site): 11 October 2021 St Dennis and Bugle Surgeries (Branch sites): 10 January 2022 Actions from fire risk assessment were identified and completed.	Partial
Explanation of any answers and additional evidence:	
<p>At our previous inspection in September 2021, we found two rooms where storage of excessive boxes and medical sundries were blocking the floor space and radiator, creating a risk to staff accessing equipment in the room and a potential fire hazard. During this inspection, we observed rooms and corridors to be unobstructed.</p> <p>There were fire risk assessments for each of the practice's three sites. However, the provider had not actioned all of the recommendations in them to reduce the risk of fire and improve safety.</p> <p>Fire alarm testing was carried out weekly at the practice's main site in Roche. However, the system for raising the alarm if there is a fire for both branch sites had only been tested once since our last inspection.</p> <p>The fire risk assessment and the practice's training records gave conflicting information about how frequently staff needed to complete fire safety training. The fire risk assessment stated that all staff needed to complete this training annually and the training records stated that staff needed to complete the training every two years. Training records showed that one member of staff had not received fire safety training at all, another member of staff had not received training in the last two years and a further 17 staff had not completed the training in the last year.</p> <p>At our previous inspection, we found that not all equipment had been calibrated. This meant that equipment used may have given incorrect readings, leading to improper treatment for patients. All equipment we sampled during this inspection had a sticker indicating that it had been calibrated.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 1 June 2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence:	
<p>At our previous inspection, records showed that 13 out of 51 members of staff had not completed the required training for Infection Prevention and Control (IPC).</p> <p>Training records provided for this inspection showed this remained an issue as some staff were overdue training for IPC.</p>	

At our previous inspection, clinical waste was not stored safely. During this inspection, we saw that clinical waste was stored safely and arrangements for the collection of clinical waste were effective.

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> <p>At our previous inspection, not all staff were up-to-date with basic life support training and sepsis awareness training. Sepsis, sometimes called blood poisoning, happens when your body overreacts to an infection and starts to damage itself. Symptoms can be difficult to spot, and sepsis can be life-threatening so it is important that staff can recognise and act on symptoms. Records seen for this inspection showed that staff had received appropriate training in basic life support and in sepsis awareness.</p>	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results, and this was managed in a timely manner.	Yes

There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence: To keep patients safe, patients were advised to contact the practice if they had not received a response about their referral in an appropriate timeframe, and the practice ran weekly searches to check that all urgent 'two week wait' cancer referrals had been sent and actioned.	

Appropriate and safe use of medicines

The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	1.00	0.80	0.79	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). (01/04/2021 to 31/03/2022) (NHSBSA)	7.5%	9.4%	8.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022) (NHSBSA)	5.55	5.37	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	205.3‰	151.6‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.86	0.66	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	4.7‰	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.	Partial
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
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.	Partial
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection in September 2021, not all patients had received the necessary monitoring to ensure that it was safe to continue to prescribe specific medicines for them and that the dose prescribed was suitable. This included patients prescribed the high-risk medicines methotrexate and azathioprine (medicines used to calm and control the body's immune system) and lithium (a medicine to help those who have mood disorders). Clinical searches completed for this inspection showed that all patients prescribed these three medicines had had the required monitoring.</p> <p>Clinical searches completed for this inspection also showed that:</p>	

- Patients prescribed amiodarone had had monitoring in line with national guidelines. This is a medicine used to treat or prevent heart rhythm disorders such as atrial fibrillation (AF).
- 1630 out of 1689 patients prescribed an angiotensin receptor blocker (ARB) or angiotensin-converting enzyme (ACE) inhibitor medicine had received the recommended monitoring. These are medicines used to treat high blood pressure and heart failure. Patients taking these medicines need to be monitored because of the risks associated with taking them.

Although prescription stationery was stored securely when received at the practice, there were no systems to ensure that the use of blank prescriptions was monitored in line with national guidance. For example, there was no tracking of blank prescriptions once they had been distributed in the practice or circulated between the practice's three sites. Therefore, there was no way to identify if prescription stationery had gone missing. The provider immediately fitted locks to printers to restrict access to blank prescriptions and set up a prescription tracking log in response to feedback we provided during our site visit.

Staff responsible for raising concerns around controlled drugs were not aware of the process for contacting the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.

At our previous inspection, we identified that checks of the emergency medicines and equipment were not carried out regularly. Checks are needed to ensure that the medicines and equipment are safe and available for use when needed. Records we looked at for this inspection showed that checks of the emergency medicines and equipment were not carried out regularly at the practice's branch sites.

At the time of our previous inspection, emergency medicines, including a medicine known to be a drug of abuse, were kept in an unlocked trolley and were accessible to patients and visitors to the practice. The trolley did not have tamper-evident seals. Since then, the provider had moved the location of emergency medicines to a staff only area and installed tamper-evident seals to the emergency trollies. However, although purchased from a reputable supplier we found one seal that could be removed and restuck without the seal being broken. Therefore, the provider could not be assured that the system was tamper-evident to ensure emergency medicines and equipment were secure and available for use when needed.

Some medicines, for example vaccines, need to be stored in a fridge to ensure they remain safe and effective to use. The practice required that the temperatures of fridges used to store medicines were checked and recorded at least once each working day. This was to ensure the cold chain was maintained and the medicines were stored safely. Records seen during this inspection showed:

- At least 65 occasions over a four month period when no fridge temperature checks had been recorded when there had been an opportunity to check them, including fridges in the dispensaries. Temperatures for some fridges had not been checked for periods of up to nine days.
- Eight occasions when the maximum temperature recorded exceeded the maximum temperature allowed to ensure the medicines remained safe and effective to use. There was no evidence that the practice had acted in accordance with their cold chain policy on these occasions.

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.	Partial
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.	Partial
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Yes
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	N/A
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Yes
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Yes
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Yes
<p data-bbox="57 1301 1098 1335">Explanation of any answers and other comments on dispensary services:</p> <p data-bbox="57 1357 1525 1570">The practice used standard operating procedures (SOPs). These were step-by-step instructions written by the practice explaining how staff were to complete routine tasks. While each SOP covered all three of the practice's sites, they did not describe the differences between the sites. Therefore, the SOPs were not always suitable. For example, the SOP describing how staff should handle waste medicines did not explain the arrangements for Bugle Surgery where the procedure was different to that at the practice's main site.</p> <p data-bbox="57 1648 1525 1715">We found evidence of cold chain breaches and a lack of oversight and monitoring in fridges used to store medicines which were required to be kept within a certain temperature.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	26
Number of events that required action:	19

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

Event	Specific action taken
A patient had developed migraine with aura while taking the combined oral contraceptive pill, but this had not been identified during a review with a GP.	GPs now had access to guidance documents.
People who have migraine with aura experience visual disturbances, such as seeing flashing lights, before their migraine.	A protocol was being developed to guide all clinicians when reviewing patients prescribed the combined oral contraceptive pill.
Patients with migraine with aura should not take the combined oral contraceptive pill because of an increased risk of stroke.	Patients prescribed the combined oral contraceptive pill were always to be asked about migraine symptoms during reviews of their medicine.
	Migraine with aura was to be recorded on patients' records as a major problem so that clinicians could easily see if it would or would not be appropriate to prescribe this medicine.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence:	
At our previous inspection in September 2021, we saw that the practice had not always acted on safety alerts issued by the Medicines and Healthcare Products Regulatory Agency (MHRA) to protect patients affected by them.	
Clinical searches for this inspection showed:	
<ul style="list-style-type: none"> 90 patients were prescribed a combination of spironolactone and an ACE inhibitor or ARB medicine. ACE inhibitor and ARB medicines are used to treat high blood pressure and heart failure. Spironolactone, a diuretic, or 'water tablet', is used to treat fluid retention caused by liver 	

disease, kidney problems or heart failure. In 2016, the MHRA advised that this combination of medicines should be used with caution and patients should be monitored at least every six months. We found 29 patients on this medicine combination had not been adequately monitored. We looked at the clinical records for five of these patients. Although all five patients were overdue monitoring, one of whom had not had monitoring for 18 months, the practice had recently invited them to attend the practice for monitoring.

- Three patients over the age of 65 were prescribed 40mg of citalopram a day. Citalopram is a medicine used to treat low mood, depression or anxiety. MHRA issued a safety alert in 2014 about the risk of heart complications in patients aged over 65 who were prescribed more than 20mg of Citalopram a day. MHRA advised a maximum daily dose of 20mg for these patients. We found that the practice had recently invited these three patients to attend the practice to discuss their medicine.
- MHRA issued a safety alert in April 2010 about avoiding prescribing the drugs clopidogrel and omeprazole at the same time. Omeprazole is a medicine used to relieve symptoms of stomach reflux and ulcers. When taken at the same time as clopidogrel, the beneficial effect of clopidogrel is reduced. Clopidogrel is a medicine used to help prevent blood clots forming which may lead to a stroke or heart attack in patients who are at risk. Therefore, for patients prescribed this medicine combination, the risk of stroke or heart attack is not reduced as much as possible. Our searches showed four patients were prescribed this medicine combination.

Effective

Rating: Requires Improvement

The practice is rated as requires improvement for providing effective services because; there was limited monitoring of the outcomes of care and treatment; and there was not always appropriate oversight of the management of patients with long-term conditions. However, staff were consistent and proactive in helping patients to live healthier lives, staff worked together and with other organisations to deliver effective care and treatment;

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.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
Explanation of any answers and additional evidence: Clinical searches completed for this inspection showed that the practice: <ul style="list-style-type: none">• Monitored patients who had severe chronic kidney disease (stage 4 or 5).• Actively followed up and completed annual reviews for patients with a diagnosis of diabetes. However, our searches showed shortfalls in the management of patients with a diagnosis of asthma. We also saw that reviews completed for patients with asthma were not effective. For example: <ul style="list-style-type: none">• 141 of the 1233 (11%) patients diagnosed with asthma had been prescribed reliever inhalers 12 or more times over the past year, indicating that their asthma may be poorly controlled. We	

looked at the records for five of these patients. Although all five patients had received a medicine review in the past year, there was no evidence that the high numbers of prescriptions for reliever inhalers had been identified.

- 103 (8%) patients had been prescribed two or more courses of rescue steroids in the last year, indicating that the control of their asthma may be poor. Three of the patients were not prescribed effective medicines for the ongoing management of their asthma
- Two of the patients records we reviewed showed the prescriptions for rescue steroids had been issued at the patient's request without an adequate clinical assessment being documented. There was no clear medicine review or asthma review for either patient. Neither of these patients' records documented whether they had been issued a steroid emergency card. This card helps healthcare staff to identify patients who are prescribed steroids to ensure that they receive appropriate treatment if they become unwell, experience trauma, surgery or other major stressors. Without the correct treatment, these patients can develop life-threatening medical emergencies.

Medicines reviews were of mixed quality. Our searches showed that 95% of patients prescribed thyroxine, a medicine used to treat hypothyroidism, had received the required monitoring. However, for three patients who were overdue monitoring, this had not been acted on when their medicine reviews had been completed.

Effective care for the practice population

Findings

The practice understood the needs of its patient population and developed services to meet and respond to those needs.

The practice supported a large number of asylum seekers, refugees and Travellers.

To improve health education and uptake of services such as cervical screening, COVID-19 vaccinations and childhood immunisations, the practice:

- sent text messages to patients both in English and in their first language
- took a 'health bus' to the Travellers' site for people to access services and advice
- set up a 'pop up hub' once a month in a local hall where people from these communities could access health advice and services, including housing advice and alcohol dependency services.

When needed, staff offered patients longer appointments with access to a translation service.

Patient information leaflets were available in a variety of languages.

The practice covered an area of high deprivation. A social prescriber supported the practice full-time, an increase since our last inspection in response to the demand. The social prescriber also offered patients support on an individual basis, for example, for those experiencing employment, housing or financial difficulties. Support included helping people to access benefits, food banks, prescriptions, carer support or services to improve mental health and well-being.

There was a high level of isolation in the community. Working with another local GP practice, funding had been secured for a 'loneliness project'. This aimed to link people together through confidential telephone calls and 'community friendship hubs'.

There was a focus on holistic care and working with other organisations and colleagues.

People with a learning disability were offered annual reviews with a nurse who had an interest in this area. These appointments were longer, and patients were supported to understand information by involving their relatives or carers and the use of easy-read or picture-based information.

The practice was veteran friendly. The social prescriber had strong connections with charities supporting veterans and patients were asked if they had ever served in the armed forces when they registered with the practice.

Management of people with long term conditions

Findings

28% of patients registered with the practice had one or more long-term conditions.

The practice's nurses and social prescriber ran a weekly group in the local village hall for people with long-term conditions, such as chronic obstructive pulmonary disease (COPD), asthma and diabetes. The group had recently expanded to include those with mental health problems and also functioned to provide respite for those caring for people with dementia. The group:

- offered health education, for example showing patients who have asthma how to use their inhalers effectively
- involved national charities and local organisations, for example to support those aiming to lose weight, for housing advice or information about diabetes
- regularly invited speakers
- included exercise.

Patients diagnosed with pre-diabetes were offered an online course.

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)	116	128	90.6%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	116	132	87.9%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and	117	132	88.6%	Below 90% minimum

Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)				
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)	117	132	88.6%	Below 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)	132	150	88.0%	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

A designated administrator was responsible for overseeing attendances for childhood immunisations and sent reminders when needed.

Parents and guardians could attend the practice at a time to suit them for their children to have immunisations.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	70.1%	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)	65.7%	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)	51.4%	54.9%	55.4%	No statistical variation

Any additional evidence or comments

Along with nurses, two of the practice's GPs were registered to do cervical screening. This meant that women who were seeing the GP for an intimate examination or contraceptive device fitting could have cervical screening at the same time if it was appropriate.

Patients could attend the practice at a time convenient for them to have cervical screening.

Monitoring care and treatment

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

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

Any additional evidence or comments

The practice attended meetings planning a trial looking at the accuracy of diagnoses of penicillin allergies based on a childhood rash.

Working with hospital colleagues, the practice helped to improve the quality of prescriptions received in hospital discharge summaries from ophthalmologists, doctors who treat eye problems. This helped to ensure that patients received the recommended medicines in a timely manner.

The social prescriber had developed a document explaining what social prescribing in GP surgeries is. This was due to be shared nationally. The social prescriber had also compiled a directory of services, which was used by GP practices throughout Cornwall.

The practice was collecting data about delays in cancer diagnoses, building on a national audit by adapting it to the needs of the practice and the local community.

The practice used an accredited tool to identify patients more at risk of hospital admission by looking at their medicines. The practice ran a search using the tool weekly. Patients with a higher (red or amber) risk rating were invited into the practice to discuss their medicines.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
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> <p>In September 2021, we found that not all staff had had an appraisal in the last year. The provider told us staff appraisals were being arranged.</p> <p>At this inspection, we saw that 13 out of 32 (41%) staff had not had an appraisal in the last year. After our site visit, the provider sent us a plan showing when they intended to complete the overdue appraisals.</p> <p>At our inspection in September 2021 we found not all the staff were up to date with the training requirements of the practice. We were told this was due in part to face to face training being cancelled during the pandemic and pressures on staff during that time.</p> <p>At this inspection we found there was a culture of learning and staff felt able to ask for advice, observe each other's practice and share their knowledge. Nurse practitioners, paramedics and GPs based at the practice benefitted from training sessions. The nursing team were returning to face-to-face training after the COVID-19 pandemic, for example about wound care, asthma and COPD.</p> <p>Staff employed in advanced clinical roles, including pharmacists, mental health workers and non-medical prescribers, were each assigned a GP supervisor. They accessed regular profession-specific support for advice and to keep up-to-date. There was ongoing monitoring of their competence.</p> <p>Staff who were responsible for reviews of patients with long-term conditions had received specific training, for example in asthma, COPD and diabetes. This allowed clinicians to refer patients to other services when appropriate.</p>	

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes

Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
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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

Any additional evidence or comments

A practice nurse had completed a cancer care course and was a 'cancer champion'.

Since our last inspection, a mental health worker had joined the practice team. They offered support for patients experiencing depression, anxiety, trauma or bereavement. They had strong links with the local community mental health team (CMHT) and had set up 'hub' meetings for the practice staff to get advice from consultant psychiatrists from the CMHT.

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence:	

The practice used Treatment Escalation Plans (TEPs). These are documents which record discussions and decisions about a patient's future care, including whether or not to attempt cardio-pulmonary resuscitation.

Responsive

Rating: Not rated

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	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:

Patients could telephone the practice between 8am and 6.30pm on Mondays to Fridays, excluding bank holidays. Calls received at the beginning and end of the day and between 12.30pm and 1.30pm were answered by a call handling service. There was a direct telephone number the call handling service, paramedics, care homes and district nurses could use.

Patients could also contact the practice using the online e-consult facility.

Patients could access a third-party GP service where they could see a NHS GP by video call to get medical advice, prescriptions or referrals, including at evenings and weekends.

However, only 12% of the patients registered with the practice had signed up for online services. The practice organised digital workshops to help more patients to feel confident using the NHS app and e-consult.

Information was posted to patients who had no access to the internet.

The practice held registers of people who are vulnerable because of their circumstances, including homeless people, Travellers, carers, frail patients and those with a learning disability.

People who are vulnerable because of their circumstances could register with the practice, including those with no fixed abode such as homeless people and Travellers.

Well-led

Rating: Requires Improvement

At our previous inspection in September 2021 we found; There was a limited system to ensure staff were up to date with their training. Staff did not always feel well informed with changes within the practice and the oversight and governance processes did not ensure systems and processes were operated or monitored effectively.

At this inspection we found that the practice had made some improvements, although some areas of work remained ongoing, and it was therefore we have rated well led as 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

Vision and strategy

The practice had a clear vision, but it was not supported by a 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.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: Not all the staff were aware of the practice's vision, values and strategy nor been involved in the development of them. This included staff who had recently joined the practice and those who had worked at the practice for some time.	

Culture

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

	Y/N/Partial
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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.	Partial
Staff had undertaken equality and diversity training.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Staff told us that arrangements had been put in place on an individual basis to support their well-being.</p> <p>At the time of our inspection, the practice manager was negotiating with an external company to provide an employee assistance programme. An app to help staff build resilience had been shared with staff.</p> <p>There was clinical expertise in menopause management in the practice. A protocol had been set up for the care of staff experiencing menopausal symptoms and training was planned for the leadership team.</p> <p>At our last inspection, staff told us that they would often be alone when opening or securing the buildings at the start and end of the day, which did not ensure their safety. 17 out of 49 staff were not up-to-date with lone working training and staff were not aware of the practice's lone working policy and procedure. Records seen for this inspection showed that staff were up to date with lone working training and staff no longer worked alone at either branch site.</p> <p>Because of the risks identified, staff working on the 'health bus' were accompanied by colleagues from the police service to help to ensure their safety.</p> <p>Staff told us that others working at the practice were approachable and they felt able to raise concerns and seek advice. However, staff were not aware of who the Freedom to Speak Up Guardian was for the practice or how to contact them. Freedom to Speak Up Guardians offer support to staff to raise concerns or speak up when they feel that they cannot in other ways.</p> <p>At our previous inspection, not all staff were up-to-date with equality and diversity training. Records seen for this inspection showed that all staff, except for one, were up-to-date with this training.</p>	

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

Source	Feedback
CQC Staff Questionnaires	Staff enjoyed working at the practice and felt proud to work there. There was an emphasis on providing high-quality care for patients.

	<p>Staff described colleagues as approachable, kind, friendly and helpful. Staff felt they worked well as a team and in a happy and supportive environment.</p> <p>Staff welcomed the opportunities to develop their skills and knowledge. Staff told us they felt appreciated.</p>
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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.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence:	
<p>Staff told us they felt clear what their roles and responsibilities were and described them clearly.</p> <p>The concerns identified at our previous inspection about the arrangements with external companies for the collection of clinical waste had been resolved.</p> <p>However, the practice's leadership team was relatively new and were still in the process of embedding recent changes into routine practice. For example, the pharmacist had helped practice staff to use the electronic recording systems, introduced during the COVID-19 pandemic, effectively.</p>	

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No
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.	Partial
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	No
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence:	

The practice had systems for identifying risks. However they did not always respond to manage or mitigate risks effectively. For example to ensure:

- that recommendations from risk assessments, such as for fire, were actioned to keep patients and staff safe
- that pre-employment checks were completed for all new staff to ensure their suitability for their roles
- the ongoing safety and security of blank prescriptions and emergency medicines and equipment.

Although the practice had systems in place, there was not always effective oversight of them to review and improve their effectiveness. For example,

- to ensure that the temperatures of fridges used to store medicines were checked and actions were taken when the temperature recorded exceeded the acceptable limit, according to the practice's policy
- to ensure that all eligible staff had an appraisal.

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial
Performance information was used to hold staff and management to account.	Yes

Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
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Governance and oversight of remote services

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
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:	
Information about how to complain was available and patients could provide feedback, compliments or complaints through the practice's website.	
Patients could complete the NHS Friends and Family Test through the practice's website. However, the practice did not review the results of this survey to celebrate or improve services.	
The provider had not carried out any patient surveys of their own. However, they were planning to carry out a survey with the practice's patient participation group (PPG).	

The PPG met every three months and included representatives from the practice clinical and management teams.

The practice carried out a patient survey with the other local GP practices in the Arbennek Primary Care Network (PCN). Information gathered was used to improve access to services for patients. For example, since our last inspection, the PCN had employed paramedics and physiotherapists who provided services for patients of The Clays Practice.

The practice contributed to meetings with the PCN and benchmarked their performance against the other practices in the PCN who share a similar patient demographic.

Working together, the PCN identified a plan to improve awareness of services for working-age men and encourage them to attend for health checks, for example to pick up pre-diabetes, depression or undiagnosed cancers, including attending local football matches and working with charities.

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

The practice supported student nurses on clinical placements and had been awarded an outstanding rating for this work in January 2022. The practice also supported medical students and was in the process of becoming a training practice for GPs.

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 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.