

Care Quality Commission

Inspection Evidence Table

Newquay Health Centre (1-540339214)

Inspection date: 7 December (GP searches) and 9 December 2021 (site visit)

Date of data download: 03 December 2021

Overall rating: Requires Improvement

We rated the location as requires improvement overall because:

- The practice did not have fully embedded systems and processes to keep patients safe: there were gaps in the safe management of medicines and staff recruitment records were not complete or up to date.
- The provider was unable to provide assurance that Infection prevention and control (IPC) measures were effective.
- The practice did not have clear and effective processes for managing risks, issues and performance.

Safe Improvement

Rating:

Requires

At this inspection in December 2021, we rated the practice as requires improvement for safe because:

- Some staff recruitment records were incomplete or not up to date.
- There was no recent evidence of Infection Prevention and Control audits having been completed 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.

Safety systems and processes

Some systems, practices and processes to keep people safe and safeguarded from abuse were not fully embedded and required improvement.

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.	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
Explanation of any answers and additional evidence:	
The practice had two safeguarding lead GPs for Adults and Children. We received 20 surveys from staff demonstrating they had access to policies and procedures, completed training and understood what to do if they suspected a patient was being abused.	

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 Public Health England (PHE) guidance if relevant to role.	Yes
Explanation of any answers and additional evidence:	
The practice had a protocol outlining the recruitment process, which was last reviewed in November 2021. This highlighted that the person specification and the use of the risk assessment table would indicate whether or not a DBS check was required for a particular role.	
There was a written induction process with examples of role specific induction for a GP registrar and receptionist. This was reviewed on 1 December 2021.	
Not all files we reviewed were complete. For example, three staff recruitment files we reviewed did not hold any interview summary records or proof that an induction process took place. Two agency staff files we looked at were incomplete and we could not be assured the correct recruitment procedures or checks had been followed.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Not known	Partial
There was a fire procedure.	Yes
Date of fire risk assessment: 30 November 2021 Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>We found some risk assessments were in place but not complete or up to date. These were:</p> <p>Electrical safety</p> <ul style="list-style-type: none"> The practice did not have an electrical safety risk assessment. We observed the use of extension leads and trailing cables mostly in offices and meeting rooms on the first floor that could be a trip hazard. We saw evidence of the last hardwire testing having been completed in May 2016, which we were told was done every five years and next due in May 2021. Portable electrical equipment had been tested and labelled in the last 12 months. <p>Fire safety</p> <p>The fire risk assessment was reviewed by the practice on 30 November 2021. However, we found some gaps:</p> <ul style="list-style-type: none"> There was insufficient information about whether fire training was being delivered as per fire safety policy. The last recorded fire drill was 6 December 2021, with six staff attending. In a Care Quality Commission survey 19 staff told us they had completed mandatory training. We sampled one staff's online training record which showed they had completed fire training. The fire risk assessment documented that the fire alarm was not being tested weekly. We looked at records and found these were last recorded in 2018. The alarm system and other equipment such as extinguishers was, however, checked annually by an external specialist and last done on 16 July 2021. There was no information in the waiting room or reception area about what to do in the event of a fire. Some flammable products were kept in a locked cupboard next to the main electrical services, but were not labelled as being a chemical or fire hazard. Other flammable products such as alcohol hand gel were seen on or near to heat sources, which could be a fire risk. <p>Control of Substances Hazardous to Health (COSHH)</p> <ul style="list-style-type: none"> The practice did not have a COSHH risk assessment or evidence of measures having been taken to reduce any associate risks with this. We found chemicals (cleaning products, alcohol gel) were stored in a locked cupboard and manufacturer's information was accessible. Liquid nitrogen was stored in an unlocked and partially labelled cupboard. We asked to see documentation and plans for the event of spillage, but the practice was unable to provide this. Suppliers documentation was kept with the cylinder. 	

- The practice immediately sent us a COSHH risk assessment after the inspection, but this required further information about the safe storage and labelling of risks such as alcohol gel, oxygen, liquid nitrogen.

The practice was unable to demonstrate whether it had taken account of national guidance or any rationale for decisions made regarding reduction of potential risks relating to :

- Cords for blinds – we found these were not secured to reduce ligature risk in most clinical rooms on the ground floor. We asked whether a risk assessment had been done, but the practice was unable to locate one and did not provide following the inspection.
- Radiator guards - the fire risk assessment checklist stated all radiators had guards fitted. However, we found some radiators not guarded which presented a scald risk. For example, furniture used by patients was placed in front of a hot radiator on the ground floor.

The practice did have:

- Appropriately trained fire wardens. Staff knew who the fire wardens were and were able to describe fire procedures, for example how patients would be escorted in the event of a fire, assistance that might be required for anyone with disabilities or reduced mobility.
- Documentation demonstrated actions taken to reduce the risk of legionella (Legionella bacteria can cause a serious type of pneumonia (lung infection) called Legionnaires' disease). Water tanks were cleaned, sinks tested and temperature restrictors fitted before the inspection by an external contractor. The building was owned by NHS Estates, which had previously carried out monthly checks of water supplies but had paused this due to the risk associated with the COVID-19 pandemic. Plans were underway for this to be taken over by the maintenance person but had not yet started when we visited.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were partially met because the provider had not recently audited these to provide assurance.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 27/11/2019	Partial
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice had an Infection Prevention and Control (IPC) policy, which was last reviewed in November 2021. However, this made no reference to the COVID-19 and current guidelines with regard to increased personal protective equipment (PPE) use and social distancing. Where the name of the practice should have been recorded this was omitted throughout the document. 	

Immediately following the inspection the practice sent a comprehensive IPC policy, which incorporated the latest guidance on managing the COVID-19 pandemic.

- Staff told us there had been management changes with staff leaving who previously held lead roles such as for IPC. Since that time, staff vacancies and changed priorities due to the COVID-19 pandemic had impacted on the IPC systems that were in place when we last inspected in 2017. For example, staff verified that no recent audits or an annual report had been completed since 2019. The practice had identified a new lead for IPC who told us they were in the process of reviewing the policy, procedures, training and planned to reintroduce audits.
- In 20 staff surveys, staff confirmed they received mandatory training at the practice, including IPC training every three years.

Senior management staff told us that two members of staff had been allocated as leads for management of COVID-19 safety measures and vaccination programme. They told us they kept up to date with daily guidance from the Department of Health and local Clinical Commissioning Group and disseminated this information daily across the team. We were told one of the COVID-19 leads had also carried out risk assessments, written specific guidance and introduced measures to limit footfall and reduce risk of cross infection when patients were in the building. The provider was unable to locate this information at or immediately after the inspection as we were told new IT systems were introduced and equipment redistributed in the building to accommodate this. Some information was later retrieved and sent to CQC demonstrating how national guidance and risks were reviewed and disseminated across the team since the beginning of the COVID-19 pandemic.

We did observe the following measures in place to reduce the risk of COVID-19 infection:

- We observed staff wore PPE that was disposed of and replaced between seeing patients.
- All clinical rooms had a checklist demonstrating increased frequency of deep cleaning and daily cleaning had been completed.
- Staff told us that extra time was built into the appointment system enabling them to clean all surfaces between patients.
- Alcohol gel was located throughout the building with signage prompting people to use it.
- People had to enter the building via an intercom, so that staff were able to limit the number of people in the waiting room.
- Social distancing was encouraged with extra space between seats to ensure safe distancing.
- There was a one-way system in and out of the building.
- Higher risk procedures that could cross infect people, such as spirometry, BP checks and ear syringing were paused as per national guidelines. Steroid injections had been paused but were now restarted with the cautionary advice given before that should the patient have any symptoms suggestive of COVID-19 they should not attend for an appointment.
- The practice had “Hot/Covid-19” clinics where patients with a suspected positive result were seen in temporary buildings outside. A similar room with a separate access from the main entrance was also available for this purpose inside the building.
- National guidance was followed to reduce patient footfall during the COVID-19 pandemic. Patients were able to use online services to access video, email and telephone consultations.

Risks to patients

There were gaps in 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.	Partial
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	Partial

Explanation of any answers and additional evidence:

There was limited evidence to demonstrate that temporary staff had an induction. However, during the inspection, the provider was able to show us an induction checklist that had previously been used and advised us this would now be re-introduced.

20 staff responded to a Care Quality Commission (CQC) Survey ahead of the inspection. Their responses highlighted themes, which were:

- The practice was normally a well-staffed practice, however there had been challenges during the COVID-19 pandemic with staffing levels due to staff sickness, isolation and delivering the vaccination programme for the community.
- All staff highlighted they were working extra hours, some were excessive but staff told us they wanted to work as a team during this time. For example, the nursing team was also covering weekends, working every Saturday morning delivering the local vaccination clinic so patients did not have to travel to the nearest mass vaccination clinic 24 miles away.
- Staff were very positive about the measures the practice had taken to alleviate the pressures on them by increasing capacity for working from home, use of locum staff to manage increased demand on certain days to help mitigate staff shortage due to sickness.
- Some nursing staff had retired and recruitment was underway at the time of the inspection.
- Staff told us there were not enough permanent GPs as some had reduced their hours of work and others had left and retired. They were aware that the practice had been doing everything it could to recruit staff but due to a national shortage of GPs and Practice Nurses this was proving difficult.
- The practice listened to staff suggestions to balance workload, for example changes were made to the duty rota sessions on a Monday due to the high stress and workload at the start of the week to share the load across the team.
- Administrative and reception staff highlighted there was increased patient demand due to population growth in the area. They told us there was a significant increase in patient registrations being made over the last three years (2018 -16,300 and 2021 – 16,850 patients registered).

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
<p>Explanation of any answers and additional evidence:</p> <p>We interviewed clinical lead GPs and received survey comments from locum and salaried GPs. We were told:</p> <ul style="list-style-type: none"> • GPs had a list of frequent attenders. These patients required continuity and were seen by their own named GP wherever possible to reduce risks. • Pathology results were now processed by the named GP rather than on a practice basis and this had also improved continuity. • The practice had a written protocol setting out management of blood tests and results. This was linked to learning and included, for example, a pathway to deal with raised blood glucose (HBA1C) results and to use coding as 'pre diabetic' to ensure the patient was appropriately monitored. 	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2020 to 30/09/2021) (NHS Business Service Authority - NHSBSA)	0.75	0.71	0.71	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). (01/10/2020 to 30/09/2021) (NHSBSA)	10.3%	10.5%	9.8%	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 (01/04/2021 to 30/09/2021) (NHSBSA)	5.43	5.34	5.32	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	119.5‰	148.5‰	126.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2020 to 30/09/2021) (NHSBSA)	0.85	0.68	0.63	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	6.1‰	6.7‰	6.7‰	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.	Partial

Medicines management	Y/N/Partial
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 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.	NA
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had systems for managing the security of blank prescription stationary. For example:</p> <ul style="list-style-type: none"> Blank prescription stationary was checked out and signed for by GPs or Locum GPs and staff could track how and when these were used. However, during the inspection we found clinical rooms were left open and unattended with blank prescription stationary kept in unsecured printers. <p>We spoke with the management team who told us that all clinical rooms could be locked. We found there were two different systems in place for monitoring blank prescriptions. Locum GPs were required to return any unused prescription stationary at the end of their session, whereas GPs did not. Staff told us they would review this process to ensure it was clear, consistently followed and provided assurance of security of prescription stationary.</p>	

Medicines management**Y/N/Partial**

There was one non-medical prescriber at the practice who had a named GP partner supervisor. An agreed prescribing list was monitored and support given to ensure they were competent to continue prescribing from it. A paramedic had joined the team and was currently undertaking the non-medical prescribing course.

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:	27
Number of events that required action:	27
<p>Explanation of any answers and additional evidence:</p> <p>We received 20 staff responses in a CQC survey. Themes highlighted were:</p> <ul style="list-style-type: none"> • Verification that the practice had processes to manage incidents, concerns and near misses which everyone was aware of. • There was some disparity: clinical staff reported full involvement in the process. Non clinical staff knew there was a system and how to report, but were not usually invited to meetings where these were reviewed and actions agreed. <p>We spoke with senior staff, including the GP lead for management of the practice. In the last nine months, the practice had a new records management system installed. They told us further training was needed as they were not fully conversant with the system. However, they were aware it provided clear review and audit prompts. The practice had introduced standardisation of recording the significant event process on the system and using it to share learning and actions taken across the team.</p>	

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

Event	Specific action taken
A review of a patient with deteriorating heart failure found that they had not been followed up as planned by the secondary care provider whose care they were under.	The patient was referred immediately for a hospital based scan. A reminder was set up in the patient record system that prompted staff to monitor follow up arrangements of patients under secondary care.
A patient with blood in their urine was later diagnosed with bladder cancer.	The practice reviewed its policy on urinalysis (checking urine samples) requiring any that showed microscopic blood to always be re-tested two weeks later.

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
<p data-bbox="57 347 810 380">Explanation of any answers and additional evidence:</p> <p data-bbox="57 398 1513 611">We carried out searches and reviewed patient records to ensure medicines safety alerts were acted on. The practice had a written process for managing safety alerts, which was last reviewed on 1 December 2021. This set out named staff responsible for receiving and managing the process. The newly implemented records management system enabled staff to access safety alerts and the lead GP partner for quality assurance to have oversight of actions taken. We saw examples of actions taken on recent alerts:</p> <ul data-bbox="108 674 1513 891" style="list-style-type: none"> • There was continued ongoing and regular searches of patients taking sodium valproate (a medicine used to treat epilepsy and bipolar disorder) with associated actions such as discussions with 11 female patients about potential risks during pregnancy to unborn children. • A medicines alert advising against prescribing two types of medicines used to reduce gastrointestinal irritation (proton pump inhibitors were frequently co-prescribed with clopidogrel) had been actioned with nine patients switched to alternative treatments. 	

Effective

Rating: Good

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
Explanation of any answers and additional evidence: 20 staff responding in a Care Quality Commission (CQC) survey verified: <ul style="list-style-type: none">• They understood their duties in regard to accessibility requirements for patients and staff.• Provided examples of how information was shared to ensure patients' needs were met, for example: Codes were applied on the patient record highlighting if they were deaf, hard of hearing, visually impaired, or had a physical or learning disability.• Clinical staff verified they used standard templates to ensure all appropriate areas of assessment were recorded and acted on for patients. For example, whether they were a carer and therefore eligible for flu vaccination and offered other support. We interviewed key clinicians as part of the inspection process and discussed our findings, outlined in the tables below.	

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age. In spite of national guidance to pause the annual health check during the COVID-19 pandemic, the practice had continued to see its patients to monitor their health.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients previously had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. However, these were paused in line with national guidelines during the COVID-19 pandemic.
- The practice had assessed the potential risks for patients with a learning disability who were offered an annual health check. In spite of national guidance to pause the annual health check during the COVID-19 pandemic, the practice had continued to see its patients to monitor their health and up to November 2021 had completed 33 of the 75 annual reviews for the year.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. In searches, we found patients had a recorded treatment escalation plan on their records.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- Significant staff resources were provided for the national COVID-19 vaccination programme for the community of Newquay which was well managed and provided closer to home access for vaccination for patients.
- There was higher prevalence of substance misuse and homelessness in Newquay. The practice demonstrated that they had a system to identify people who misused substances. There was a lead GP with special interest in substance abuse. The practice had close links with third sector agencies and supported patients who wanted to detox and or be rehabilitated. The practice had plans to develop a service specifically for homeless people, which the practice was driving and working with third sector agencies to set up.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

We carried out clinical searches and sampled patient records to establish whether the management of their conditions was effective. We found:

- In a search for potential missed diagnosis, fourteen patients' records showed the practice followed up any patients whose blood results suggested they could be diabetic. Of the 14, one patient's repeat blood test confirmed a diagnosis of diabetes and they were referred to the Diabetic nurse specialist within the team for follow up.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. For example, Health Care Assistants (HCA) were trained to take a patient's pulse and to identify when to escalate, for further review. HCAs had picked up two patients with suspected undiagnosed atrial fibrillation (irregular heartbeat that can cause dizziness, shortness of breath and risk of blood clots developing in the heart which could lead to a stroke), who were now receiving appropriate treatment and monitoring to reduce associated risks with the condition.
- GPs followed up patients under and over 18 who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions. For example, working closely with secondary care specialists to alter Clinical Commissioning Group area guidance to encourage the use of powder inhalers.
- 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. In line with national guidelines, spirometry (used to diagnose this respiratory condition) was not being done due to the risks of cross infection during the COVID-19 pandemic. However, patients were asked about any key changes to their breathing during telephone reviews as per current guidelines.
- Patients with asthma were offered an asthma management plan. All patients using inhalers had been reviewed and offered an alternative inhaler to reduce the impact on the environment. However, in searches we found out of 64 patients on inhalers for asthma one patient could be at greater risk as they were using more than 12 inhalers per year. GPs were aware of this and taking action with support from the clinical pharmacist. The practice was trying to recruit a Respiratory Nurse Specialist but had no applicants with suitable experience or qualifications. An established practice nurse was booked to start the Respiratory Management Diploma in January 2022 and would be gradually taking over responsibility for monitoring patients.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	189	198	95.5%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	143	156	91.7%	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) (01/04/2019 to 31/03/2020) (NHS England)	143	156	91.7%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	143	156	91.7%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	163	179	91.1%	Met 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Any additional evidence or comments

The practice closely monitored and were proactive in contacting parents to set up appointments for children who were due immunisations.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2021) (Public Health England)	73.6%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	71.7%	74.8%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	65.0%	66.8%	63.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	60.2%	53.5%	54.2%	No statistical variation

Any additional evidence or comments

We asked the provider about low uptake rates for cervical screening. They told us that the high levels of deprivation and other social issues experienced by the patient population resulted in challenges in securing attendance for cervical screening. However, we saw that action was underway to improve uptake including 'patient safety' searches to help to manage patient recall for these patients. Patients were being contacted, including via text messages and offered flexible appointments. Since April 2021, the practice had also run Saturday clinics to increase patient uptake of cervical screening with 700 outstanding completed since then.

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

Cervical screening audits were carried out every two weeks by qualified clinical staff. This provided continual assurance that samples were accurately taken, repeated where necessary and followed up. Cervical smear takers told us that where needed further training and support would be offered, but all results demonstrated high levels of competence within the team.

An environmental risk assessment specifically for general practices was carried out which highlighted areas of risk and suggested actions to reduce carbon emissions. The practice had taken these steps, for example by reviewing all patients with inhalers and any held with emergency equipment and replaced these for environmentally friendly alternatives.

Patient access audits were regularly carried out every month. This looked at demand and capacity when patients were calling by telephone for assistance. The practice identified call abandonment, busiest periods and the number of calls on average received per month. The data demonstrated the practice was handling a high level of telephone calls, nearly 14,000 per month. The team made changes to rotas and had more staff answering telephones at peak times of the day.

Any additional evidence or comments

The practice had two research GPs and two research nurses carrying out a mixture of commercial and non-commercial research projects. The research lead at the practice was also the Head of the Cornwall Research Network. At the time of inspection, the practice was contributing to a study looking at the benefits and safety of injectable anti-hypertensives (6-month depot). The aim of this research is to establish whether patients with high blood pressure can receive effective treatment twice a year in the form of a depot (injected into their arm) rather than taking tablets every day.

Effective staffing

The practice had fallen behind with some staff appraisals that would demonstrate continuity of skills, knowledge and experience to carry out their roles. Induction records were incomplete or not available for newly appointed staff in the previous 12 months.

	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.	Partial
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>There was limited evidence to demonstrate a comprehensive induction for staff at all levels had been completed. However, during the inspection, the provider was able to show us an induction checklist that had previously been used and advised us this will now be re-introduced.</p> <p>Recently recruited staff were able to explain their induction process, however there was no documentation to reflect this.</p> <p>The practice told us that staff annual appraisals had been delayed due to the Covid-19 pandemic, and we were shown evidence on the day of the inspection that both clinical and non-clinical staff were scheduled to receive appraisals in January and February 2022.</p> <p>In a CQC survey, GPs verified they had received:</p> <ul style="list-style-type: none"> • An up to date appraisal and Teamnet training, in-house mentor meetings, Significant Event Analysis (SEA) meetings, regular informal chats and received feedback. • Support to complete their Continuing Professional Development (CPD) as the practice had an annual subscription to online medical resource websites for regular updates. • Mandatory training. • Attended clinical meetings in-house including Significant Learning Events, educational meetings, held membership of two peer groups and a national doctor's online group. • GPs undertaking specific tasks, for example implant and coil insertion had completed advanced training and received regular updates in the area of sexual health. <p>Other staff responding in the CQC staff survey told us about specific training they had completed for their roles, for example:</p>	

- An administrator was supported to complete a Business and Administration Diploma.
- A practice nurse had completed the Diabetes Management Diploma and had training for injectable therapy for diabetes.
- A practice nurse had completed the Faculty of Sexual and Reproductive Health (FSRH) training for implant insertion and removal
- Practice nurses responsible for managing patients wound care confirmed they had received updates as required, for example for leg ulcer management and compression that was required every three years.

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centered care when they moved between services.	Yes
Explanation of any answers and additional evidence:	

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
<p>Explanation of any answers and additional evidence:</p> <p>National guidelines recommended that GP practices should pause some health assessments and checks during the COVID-19 pandemic to reduce footfall and risks for patients and staff. However, the practice considered the risks, put measures in place and continued to provide health checks for:</p> <ul style="list-style-type: none"> Annual health check for people with learning disabilities because they had built a good rapport with people who trusted them to monitor their health care. <p>Some national priorities and initiatives were paused. However, staff demonstrated they were aware of, and advised patients of the associated higher risk of serious illness from COVID-19 infection for people trying to tackle obesity or from Black, Asian and minority ethnic backgrounds (BAME). People continued to receive support to reduce weight, be vaccinated or shield according to these risks.</p>	

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:

In a CQC staff survey, we received 20 responses that verified:

- Staff understood all aspects of obtaining appropriate consent from patients
- Staff had received training on the mental capacity act and that this was mandatory.

In interviews, staff shared examples of how they obtained consent and where they recorded this within standardised assessment templates, including the discussion of any risks and benefits, for example before any minor surgery was done.

Caring

Rating: Good

Newquay Health Centre was rated Good for the provision of caring services at the previous inspection in December 2017. In accordance with Care Quality Commission methodology, the ratings from our previous inspection for this key questions (responsive) have been carried through to contribute to the overall rating for the practice.

Responsive

Rating: Good

Newquay Health Centre was rated Good for the provision of responsive services at the previous inspection in December 2017. In accordance with Care Quality Commission methodology, the ratings from our previous inspection for this key questions (responsive) have been carried through to contribute to the overall rating for the practice.

Well-led Improvement

Rating:

Requires

At this inspection in December 2021, we rated the practice as requires improvement for well led 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 that 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.

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
<p>Explanation of any answers and additional evidence:</p> <p>We interviewed the GP partner management lead about the pressures on the workforce and actions to recruit new staff. Since the last inspection, the practice had changed its model of delivery to being a multidisciplinary workforce and listened to patients views on this.</p> <ul style="list-style-type: none"> • The nearest mass vaccination centre at Wadebridge had closed. Transport links were poor and the distance to the nearest centre meant that many patients would not be able to attend. The practice and Primary Care Network (PCN) took the decision to vaccinate the community itself closer to home which had created further pressures on the limited workforce. • We were told the creation of the PCN enhanced staffing resources with four social prescribers, a pharmacy technician, pharmacist and paramedics recruited and shared with two other practices in the area. • A digital healthcare provider was commissioned by the Clinical Commissioning Group (CCG) to support practices including Newquay Health Centre during the COVID-19 pandemic. Patients were able to access remote consultations via this service, which was well received but had discontinued in November 2021 due to funding. 	

- Senior leaders had links with the universities and meetings were in progress to develop placements for newly qualified nurses interested in having a career in Primary Medical Services.
- The practice had moved to a model empowering patients so they could decide whether they wanted a telephone or face to face appointment.

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had a documented ethos and mission statement with the primary aim of ensuring patients received high quality, innovative and caring services. • Leaders were aware of the current challenges they were facing and had a strategy to address the future of the service. • Leaders at all levels were visible and approachable. They worked closely with staff to ensure they prioritised compassionate and inclusive leadership. • 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"> • Staff we spoke with told us they felt confident to raise concerns if needed and they knew that appropriate actions would be taken. • The practice had a low turnover of staff and staff told us they felt supported within their roles. • The practice issued a monthly newsletter to staff which contained up to date information on any changes affecting the practice. 	

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

Source	Feedback
CQC staff survey	20 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 staff feeling stretched due to recruitment challenges, retirements and increased priorities during the COVID-19 pandemic. All of the staff responding highlighted that they felt the provider was listening, making changes to improve their well-being and secured additional resources where they could.

Governance arrangements

The overall governance arrangements were ineffective. Clinical and internal audit processes are inconsistent in their implementation and impact.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Yes

Explanation of any answers and additional evidence:

The arrangements for governance and performance management had been identified by the practice as needing improvement. Evidence seen throughout the inspection supported this as governance was not fully clear and had not always been operating effectively in the last two years. For example:

- Staff recruitment records did not provide assurance of safe appointments being made.
- New systems had been poorly implemented with staff confused and not fully conversant with them or where they could access information or evidence seen at previous inspections.
- Systems and processes were not in place to ensure an effective oversight of complaints.

The governance arrangements, the strategy, and plans were under review. However, through the course of the inspection we found staff were not always clear about their roles, what they are accountable for, and to whom. For example:

- We found Health and Safety requirements were not fully in place with incomplete or missing risk assessments to demonstrate mitigation of these by actions taken.

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.	Partial
There were processes to manage performance.	Partial
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence:	
<p>We found areas where management of risks, issues and performance needed improvement:</p> <ul style="list-style-type: none"> The practice did not have fully embedded systems and processes to keep patients safe: there were gaps in the safe management of medicines and staff recruitment records were not complete or up to date. There were gaps in the identification of potential Health and Safety risks. The provider was unable to provide assurance that Infection prevention and control (IPC) measures were effective. Reduced staffing resources coupled with the COVID-19 pandemic and longer term challenges of recruitment had the potential to affect resilience of the team. <p>Since September 2021, the practice had reviewed and improved the following measures to manage risks, issues and performance. As these were newly revised further time was needed for these to be embedded and demonstrate positive impact:</p> <ul style="list-style-type: none"> The implementation of some quality improvement initiatives, including the reintroduction of significant learning so all staff at the practice were included. Reviewed and implementation of standard operating procedures, for example for IPC in line with NICE guidelines. <p>We saw some examples of where there were effective processes for managing risk including:</p> <ul style="list-style-type: none"> The provider had maintained service provision to the population for the duration of the pandemic. During this time, staff were supported with remote working solutions where possible and practical, and occupational health services were offered as support to all staff. The practice continued to operate when workforce numbers were depleted through illness, isolation and unplanned absences. There had been a review of ways to promote ongoing sustainability of quality of care including utilising shared resources across its membership of the Primary Care Network and introduction of 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 chose 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 improve healthcare for vulnerable people in the area.
- The practice population was significantly increasing, with further local population projected growth of 20,000 – 30,000 in the next five years. The practice had applied for funding for a new build to accommodate the increasing healthcare needs of the community.
- The national clinical staffing crisis was impacting recruitment in the area. Links with academic establishments were being utilised to support newly qualified nurses who might be interested in a career in primary medical services with mentored work placements.
- Use of regular Locum GPs for continuity.
- Temporary management assistance from a retired member of staff to support implementation of systems and processes.
- Access risks were identified for vulnerable patients and telephone access increased; links with the community nursing team were further strengthened and utilised to monitor patients at risk. Care Home ward rounds continued with named GPs doing these.

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

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

	Y/N/Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>The local mass vaccination centre had closed and the nearest one for patients to attend was 24 miles away. Three practices, including Newquay Health Centre decided to provide this service near home as many patients did not have the means or finances to attend the nearest mass vaccination centre. Up to December 2021, the Primary Care Network (PCN) had given 35,000 vaccinations, of which a third had been done by Newquay Health Centre staff.</p>	

Appropriate and accurate information

There was a demonstrated commitment to using data and information to drive and support decision making but did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to monitor and improve performance.	Yes
Performance information was used to hold staff and management to account.	Partial
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
Explanation of any answers and additional evidence:	
<p>The information used in reporting, performance management and delivering quality care was not always accurate, valid, reliable, timely or relevant. Leaders and staff did not always receive information to enable them to challenge and improve performance. Information was used mainly for assurance and sometimes for improvement. For example:</p> <ul style="list-style-type: none"> • The practice had a detailed complaints policy, but we saw instances where complaints had not been dealt with appropriately. There was no record of some patients having received either a written acknowledgment or a response to their complaint. • Staff annual appraisals had been delayed due to the Covid-19 pandemic, and we were shown evidence on the day of the inspection that both clinical and non-clinical staff were scheduled to receive appraisals in January and February 2022. • In response to a CQC survey staff told us they would like more regular staff meetings and for learning from significant events to be shared. 	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes

The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	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 actively encouraged feedback about the services provided through the completion of the friends and families survey, the practice website and discussions with the practice's patient participation group (PPG)• The practice has been open throughout the pandemic.• Staff felt supported in suggesting ideas and changes. For example: Communication was increased within the community via the local paper, radio and television to ensure patients were aware that the practice was open and able to see patients face to face.	

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none">• We spoke with a representative from the Patient Participation Group (PPG) who told us that there were 25 members, however due to the COVID-19 pandemic the members had not been able to hold their regular meetings.• The PPG had been developed to enable the GP partners at the Health Centre to gain feedback from the practice population and to agree areas of priority and collate patients views on improving the service.• Information about the PPG was available in the practice and on the website.

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:	
<p>The practice provided placements for registrars training to be qualified GPs, doctors and medical students. Three GP partners were trainers providing support and tuition for staff on placement. At the time of the inspection, there were three GP registrars, a medical student and a foundation (level 2) doctor on placement.</p> <p>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.</p> <p>Feedback from the placements was positive as they felt supported and listened to.</p>	

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