

Care Quality Commission

Inspection Evidence Table

Alverton Practice (1-7263119052)

Inspection date: **23 August 2022**

Date of data download: 17 August 2022

Overall rating: Good

Safe

Rating: Good

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
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.	Y

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Y

Alverton Practice: Various dates Newlyn Surgery: April 2022 Cape Cornwall: November 2021	
There was a fire procedure.	Y
Date of fire risk assessment: Alverton Practice: April 2022 Newlyn Surgery: April 2022 Cape Cornwall: November 2021 Actions from fire risk assessment were identified and completed.	P
Explanation of any answers and additional evidence:	
<p>The practice had oversight of health and safety risk. For example:</p> <ul style="list-style-type: none"> Alverton Practice was located in St Clare Medical Centre which was shared with two other GP practices. A facilities manager, who had oversight of health and safety and was responsible for carrying out remedial work, was employed by the practices. While we identified that not all actions from the health and safety risk assessment for Alverton Practice had been completed, the facilities manager demonstrated that items requiring immediate action were prioritised. The practice was aware of what items were outstanding as they had regular meetings with the facilities manager to discuss this. On inspection we saw an action plan of required works. Daily and weekly health and safety checks were carried out for the practice environment. These checks were recorded as completed on check lists which were displayed in each room. However, the check lists did not demonstrate what was included in this process. <p>The practice had completed the majority of items requiring action from their fire risk assessments. For example, we found appropriate signage had been replaced at the Cape Cornwall branch and that fire door seals had been ordered. However, there were some actions which had not been completed as recommended or in line with best practice. For example:</p> <ul style="list-style-type: none"> The practice had conducted six monthly fire drills at the Cape Cornwall branch site to ensure their procedure was effective and that staff were aware of actions to take in the event of a fire. We reviewed the practice's fire log book which showed that fire drills had been conducted. However, there was no information available to demonstrate if their fire procedure had been followed effectively or if learning was identified as part of the fire drill exercise. For example, no information had been recorded to demonstrate if all staff and patients had been accounted for as part of this process, or if the building had been evacuated efficiently. The practice was unable to demonstrate that a fire drill had been completed for their Newlyn Surgery branch. We raised this with the practice at the time of inspection. They told us that during the Covid-19 pandemic, the Newlyn branch had been closed and this had been an oversight when they had reopened the branch. The practice gave assurances that a fire drill would be scheduled. Following inspection the practice sent us evidence to demonstrate that they had subsequently undertaken a fire drill at the Newlyn branch. We saw evidence that weekly fire alarm tests had been conducted across the three practice sites. However, we identified that when the members of staff responsible for undertaking the tests were away, these tests were not conducted. We identified three dates in July 2022 when fire alarm tests had not been done. We raised this with the practice during inspection and following inspection, the practice told us that they had identified additional staff who would be trained to conduct fire alarm checks to ensure these oversights did not reoccur. 	

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.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 18 June 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	
Explanation of any answers and additional evidence: The practice had acted on areas identified in their infection prevention and control audit. For example, their audit identified that chairs used by patients did not adhere to appropriate standards and were permeable to infection. The practice had replaced these with chairs which met necessary standards and were able to be thoroughly cleaned.	

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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
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.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y

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. ¹	P
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y

Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence: The practice stored the paper copies of patient records in a room which was secured with keypad entry and they advised that only authorised persons had access. However, the storage room was shared with two other practices in St Clare Medical Centre. Patient records had not been additionally secured to ensure access to the records was limited to persons from Alverton Practice. Potential risk had not been assessed by the practice. However, following inspection the practice sent us evidence that they had conducted a risk assessment for this. Actions identified to mitigate risk included introducing a standard operating procedure to be signed by all practices who had access to the records room.	

Appropriate and safe use of medicines

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

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

We were unable to obtain practice comparable data for prescribing indicators as part of this inspection. (no published data was available for us to review from our external published sources).

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
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.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. ¹	Y
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.	Y
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. ²	P
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y

Medicines management	Y/N/Partial
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
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.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
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.	P
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	P
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>As part of our inspection process, we conducted remote clinical searches of patient records prior to our inspection visit. We found that while the majority of patients' care and treatment was up to date, we identified that not all patients had received appropriate monitoring. For example:</p> <ul style="list-style-type: none"> 26 patients prescribed gabapentin (used to treat seizures) had not received a review in the previous 12 months. We reviewed five of these patients and identified that no medicine reviews had been conducted by the practice. One patient had not received a medicine review even though they had attended the practice for care and treatment on several occasions. <p>We raised this with the practice during a remote interview on 17 August 2022 who gave us assurances that they would review these patients. When we conducted our site visit on 23 August 2022 the practice confirmed that all patients identified through our searches as requiring monitoring had been invited in for a review. As a result, some patients had already received a review or had booked an appointment. Patients who had not engaged with the practice had been changed to a seven day prescription to encourage them to contact the practice.</p> <p>The practice told us that in March 2021 they were given six weeks' notice that their clinical system was going to change as there was no longer going to be national funding provided for their current system. This change affected a number of practices in the county of Cornwall. The lead up to this process would usually take approximately three months to ensure patient records including clinical coding was transferred accurately and staff received appropriate training. The practice told us that the reduced notice period had meant they weren't given in-depth training to demonstrate how more complex clinical searches could be conducted to better monitor patients' care and treatment. In April 2021 a pre-planned merger with Cape Cornwall was finalised which meant practice time and focus had been prioritised on embedding new processes and managing changes to staff dynamics. This had hindered the practice's ability to dedicate the time to further familiarise themselves with the new system. Following our remote searches, the practice advised that they would add the searches to their monthly audits to ensure continued monitoring for the patient groups identified. They also confirmed that additional face to face training on their clinical system was booked for September 2022. This was the earliest available date they were able to book onto.</p>	

Medicines management	Y/N/Partial
<p>Medicines which required cool storage were stored in dedicated fridges. The temperature of the fridges were checked manually each day and temperatures were recorded in a log. Staff were able to describe the action taken should the fridge be outside of the recommended range. Once a week an electronic reading was taken from an internal thermometer and the data analysed to ensure the fridges were operating in the recommended temperature ranges at all times.</p>	
<p>Emergency equipment and medicines were available to staff for use in an emergency. These were stored in a locked room near the consulting rooms. Every four weeks the practice checked all emergency medicines and emergency equipment to ensure they were in date and safe to use. A tamper evident seal was then attached to the bag and its serial number logged. The tamper evident seals were checked daily to ensure they were intact. A notice was clearly displayed identifying where to find specific equipment within the bag.</p>	
<p>Medical equipment was not always stored securely. During our inspection we identified that consulting rooms were left unlocked including rooms where sharps such as needles and scalpels were stored. At one of the branch locations, medical equipment such as needles was stored in a cupboard by the reception desk. Staff we spoke with confirmed that the cupboard was not locked. However, they told us that someone was usually always behind the reception desk. If they had to step away for a particular reason, they would either ensure one of the clinicians working from the branch had view of the reception area or they would limit access to the building for the general public for a short period of time. The impact of this and the potential risk of unauthorised access to medical equipment had not been assessed by the practice. Following inspection, the practice sent us evidence that they had conducted a risk assessment and installed locks to storage cupboards.</p>	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
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.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y
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.	NA
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
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.	Partial
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Y

Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y
<p>Explanation of any answers and other comments on dispensary services:</p> <ul style="list-style-type: none"> The dispensary was locked when not in use and the key stored securely. Staff signed the key out prior to entering the dispensary. Dispensary staff carried out checks to ensure safe working practices. Stock was reviewed and medicines nearing their expiry date were clearly labelled. All prescriptions were signed prior to the medicines being dispensed. The dispensary staff provided medicines in a monitored dosage system (MDS) for named patients registered with the practice. We identified that the practice had introduced systems to reduce associated risks. For example, the MDS were filled during the afternoons which were quieter and enabled less distractions. However, processes to reduce risk where best practice guidance had not been followed, had not always been recorded. We identified that following a request by a patient's carer, a medicine provided in a MDS remained in the foil. Staff told us that the risks of this had been discussed at the time of the request, but they were unable to demonstrate this as it had not been formally documented. Controlled drugs (CDs) were stored in a double locked metal cupboard. One member of staff signed the key out and ensured the key remained on their person while they were at work. Staff maintained a CD register which showed the balance of medicines held, dispensed and destroyed. We checked the register for three controlled drugs and found the balance reflected what had been dispensed. Any prescriptions which contained controlled drugs were dispensed and stored in the CD cupboard while waiting collection or delivery. The delivery driver was required to sign a document which evidenced they had collected CDs from the dispensary. Prescriptions were managed electronically. All prescription paper was stored in locked printers in each clinical room. Replacement paper was stored securely and signed out to either the prescribing clinician or the dispensary. 	

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.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	24
Number of events that required action:	24
Explanation of any answers and additional evidence:	

The practice had adopted the general medical council definition of a significant event and had not had any events in the last 12 months that met that threshold. They identified and recorded clinical errors and associated local learning events separately. In the last 12 months they had 24 clinical errors recorded. We saw evidence that each one had been reviewed, learning identified where necessary and then discussed at a clinical governance meeting. When we inspected, the practice did not have a process for recording and investigating learning events that were not clinical. They told us that if non-clinical errors occurred they would be dealt with in the respective teams. However, there was no practice oversight to ensure learning was identified and disseminated consistently. Following inspection, the practice confirmed that they would introduce this aspect of learning to their process enabling the review of non-clinical errors at a practice level.

Example(s) of significant events (“clinical errors” as determined by the practice) recorded and actions by the practice.

Event	Specific action taken
A patient had been prescribed controlled drugs but had been dispensed with too few tablets.	The staff had implemented an additional checking system to ensure this did not happen again.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	P
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff were made aware of any safety alerts by email and discussion in team meetings. If the alert related to a medicine stocked in the dispensary, an immediate check was made, and action taken to maintain and promote safety. For example, checking batch numbers and removing any affected medicines from the shelves so that they would not be inadvertently dispensed. A folder was available which contained previous safety alerts for staff to reference when needed.</p> <p>Due to the change in clinical system and lack of appropriate training, the practice had not set up routine audits on all applicable historical safety alerts. When we conducted our remote searches, we identified four patients prescribed Mirabegron who did not have up to date blood pressure checks. We raised this with the practice during a remote interview on 17 August 2022 who gave us assurances that they would review these patients. When we conducted our site visit on 23 August 2022 the practice confirmed that these patients had been invited in for a review and prescriptions had been changed to a seven day prescription to encourage them to engage with the practice. During inspection the practice gave us assurances that this patient cohort would be included in their monthly audits to ensure reviews remain up to date. However, there was no formal documentation to evidence how this would be completed.</p> <p>We saw evidence that the practice conducted annual audits for women of childbearing age prescribed sodium valproate and necessary actions taken to mitigate risk.</p>	

Effective

Rating: Good

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y

Effective care for the practice population

Findings
<ul style="list-style-type: none">• The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.• Health checks, including frailty assessments, were offered to patients over 75 years of age.• Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.• The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

The practice told us that there was an error with clinical coding on patient records brought about by the imposed change in clinical system. They told us that the new system applied long term condition codes to patient records when they had never been diagnosed with one. In order to reconcile this error, the practice ran monthly audits on patients with long term condition coding, conducted a full review of their record and either invited them in for a review or removed the code as required. We saw evidence of the monthly audits and reviews they conducted to ensure patients received appropriate care and treatment.

Our remote clinical searches identified that not all patients with long term conditions had received appropriate monitoring. For example:

- We identified 10 patients diagnosed with an underactive thyroid gland who had not had a thyroid function test in the previous 18 months (hypothyroidism a condition where the thyroid gland does not produce enough hormones. This can cause weight gain, tiredness and depression). We reviewed five of these patients and found that that all were overdue monitoring. For three of these patients, they had not received necessary monitoring since 2020.

We raised this with the practice during a remote interview on 17 August 2022 who gave us assurances that they would review these patients. When we conducted our site visit on 23 August 2022 the practice confirmed that these patients had been invited in for a review and prescriptions had been changed to a seven day prescription to encourage them to engage with the practice.

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.

- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	45	52	86.5%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	43	47	91.5%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	42	47	89.4%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	42	47	89.4%	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)	47	57	82.5%	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>

Cancer Indicators	Practice	CCG average	England average	England comparison
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(Snapshot date:) (UK Health and Security Agency)		N/A	80% Target	-
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (to) (UKHSA)		-		N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (to) (UKHSA)		-		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)	47.6%	54.9%	55.4%	No statistical variation

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

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.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
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.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y

There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
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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.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

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.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: The practice had identified challenges in encouraging local fisherman to engage with medical professionals. As a result, they conducted a drop in clinic on the harbourside to reach this population group. This clinic was open to all and not just targeted for patients registered with the practice. The practice told us they had managed to conduct 12 general health checks and 14 mole checks which had led to two patients being referred to the local hospital using the two week-wait referral process.	

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.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Y
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Explanation of any answers and additional evidence:
 Our clinical review of notes where a DNACPR decision had been recorded identified that where possible patients' views had been sought and respected. We saw that information had been shared with relevant agencies.

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y

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.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y

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.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y

When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y

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

Source	Feedback
Remote staff interviews	We spoke with five members of staff prior to inspection who all reported that they felt supported by the practice and that there were positive relationships between managers and staff.
CQC staff questionnaire	We received 14 completed staff questionnaires. Feedback included: <ul style="list-style-type: none"> • Staff felt supported. • Practice leaders and managers were approachable. • Staff felt able to raise concerns. • There was a positive working atmosphere.

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.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y

When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had identified an issue with clinical coding which had occurred as a result of an imposed change of clinical system. As soon as they became aware of this, they identified required actions to reconcile this system error. The practice also applied for funding from the local commissioner in order to assign dedicated staff to reviewing patient records. When we inspected, they had not received any financial support from commissioners but had instead been conducting the necessary reviews of patient records in addition to routine work.</p> <p>Practice oversight was not fully embedded to ensure risks were acted on or identified as necessary. For example:</p> <ul style="list-style-type: none"> • Fire drills had not been conducted at a branch location in line with their fire risk assessment. • Fire alarm checks were not conducted when key practice staff were absent. <p>The practice had acted on areas of concern and following inspection, they sent us evidence that risks identified had been addressed.</p> <p>Systems were not fully embedded to proactively identify patients requiring monitoring for their care and treatment. For example, for patients diagnosed with hypothyroidism and patients affected by historical safety alerts. However, the practice had acted promptly to concerns identified and gave assurances patient cohorts identified would be added to their monthly audits.</p>	

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.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>During the pandemic the practice had become one of the Covid- 19 vaccine sites for the county and estimated that they had administered approximately 100,000 vaccines. The practice were aware of the challenges in administering the vaccine for their local population and had set up clinics at local events in order to immunise harder to reach population groups. For example:</p>	

- The practice had set up a vaccine clinic on the harbourside in order to administer vaccines to local fishermen.
- They had set up a vaccine clinic during a local music festival to encourage uptake among younger age groups. They told us that they had managed to administer 400 vaccines over the weekend festival.

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.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y

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

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.	Y

The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence: One member of staff told us that following the practice merger in April 2021 concerns were raised with management that they did not want to change practice sites as originally planned. As a result, management had made adjustments to enable this member of staff to work at their preferred location.</p>	

Continuous improvement and innovation

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

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

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.