Care Quality Commission

Inspection Evidence Table

Penntorr Health (1-2017759954)

Inspection date: 6 November 2019

Date of data download: 30 October 2019

Overall rating: Requires Improvement

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

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
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	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
Staff who acted as chaperones were trained for their role.	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
Explanation of any answers and additional evidence: The practice had last reviewed the safeguarding adults and safeguarding children policies in October 2019. We saw that all staff had completed safeguarding adults and safeguarding children training to the relevant level for their role and had undertaken refresher training in accordance to the practice's	

Safeguarding	Y/N/Partial
safeguarding policies. The practice manager had an overview of Disclosure and Barring Service (DBS) checks to ensure this had been undertaken for all relevant staff.	

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 Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence: The practice's recruitment policy had been reviewed in October 2019. We looked at three staff files and found recruitment checks had been undertaken in line with the policy. The practice manager had an overview of recruitment checks for all staff employed at the practice to ensure all relevant documentation had been obtained before staff commenced employment.	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: Penntorr Health February 2019, Millbrook Surgery February 2019	Y
There was a record of equipment calibration. Date of last calibration: Penntorr Health February 2019, Millbrook Surgery February 2019	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: Penntorr Health; 29/08/2019, Millbrook Surgery; 24/06/19	Y
There was a log of fire drills. Date of last drill: Penntorr Health; 3/09/2019, Millbrook Surgery; 22/10/3019	Y
There was a record of fire alarm checks. Date of last check: Penntorr Health; 24 October 2019, Millbrook Surgery; 24 October 2019	Y
There was a record of fire training for staff.	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: Penntorr 15/09/2019, Millbrook 10/09/2019	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: Fire policies and procedures were accessible for all staff at Penntorr Health and Millbrook Surgery; both electronically and in files within reception areas. Following an external risk assessment at Penntorr Health, all actions identified had been completed. No actions had been identified during an internal fire risk assessment undertaken at Millbrook Surgery. There were five appointed fire marshals who had all received relevant training. In accordance to the practice's policy, fire alarms were due to be tested each week. However, we found that fire alarm tests at Penntorr Health had not been completed each week; Tests had been completed 21 weeks out of 44 total weeks between January and October 2019.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: July 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: July 2019	Y

Explanation of any answers and additional evidence:

The practice had a risk register which assessed the impact and likelihood of risks to health and safety which included;

- Exposure to hazardous substances
- Infection prevention and control
- Building environment
- Security
- Legionella (Legionella is a term for a bacterium which can contaminate water systems in buildings.)
- Personal safety

The practice had a legionella policy and procedure. Legionella is a term for a bacterium which can contaminate water systems in buildings. We saw that legionella checks for Penntorr Health was undertaken by the facilities management team from the owner of the premises. The practice had copies of all relevant paperwork including regular checks of water temperature.

An external risk assessment had been completed in September 2019 for the branch, Millbrook Surgery. We saw that actions identified as requiring immediate action had been completed. For example, the practice had replaced two water tanks as advised. There was a plan for the completion of other identified actions required. We saw that checks of water temperature had been completed each month.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
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: May 2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	Partial
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

A practice nurse was the infection prevention and control lead who undertook regularly audits of decontamination of equipment and environmental cleanliness.

The infection prevention and control audit undertaken at Millbrook Surgery in May 2019 had not identified that the external cleaning company had not kept records to confirm general cleaning had been completed. We saw that Millbrook Surgery looked clean. We received 18 CQC comments cards, none of which referred to the uncleanliness of the site. A monthly environmental audit documented that the Surgery was observed to have been cleaned.

Staff were assessed during induction to ensure they understood and undertook correct hand hygiene and hand washing techniques. All staff had signed the infection prevention and control policy to confirm they had read and understood it.

We saw that the practice kept records to confirm that daily cleaning of clinical rooms and specialist equipment had been completed at Penntorr Health and Millbrook Surgery.

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
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely	Y

unwell patient and had been given guidance on identifying such patients.	
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	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.	Y
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
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented 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
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y

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) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	1.04	0.90	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2018 to 30/06/2019) (NHSBSA)	10.4%	9.4%	8.6%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) (NHSBSA)	7.02	5.76	5.63	Variation (negative)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	5.17	2.55	2.08	Variation (negative)

Explanation of any answers:

The practice was aware that two out of four prescribing indicators were higher than local and national averages. The practice told us they had been working with the medicines optimisation team from Kernow Clinical Commissioning Group (KCCG) to reduce prescribing of antibiotics used to treat uncomplicated urinary tract infections and Nonsteroidal anti-inflammatory drugs (NSAIDs).

The practice told us that the average daily quantity of oral NSAIDs prescribed was higher than local and national averages because they had a large number of patients who were being prescribed NSAIDs on weekly prescriptions, each of which counted as one unit.

A Primary Care Network (PCN) pharmacist was due start work at the practice for two days per week in January 2020.

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).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	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.	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.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England 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.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

Explanation of any answers and additional evidence:

We noted that not all PGDs had been signed by all staff from the date the PGD was valid from. However, at the time of inspection, Patient Group Directions (PGDs) used to administer medicines had been signed by all appropriate staff. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.).

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:	11
Number of events that required action:	11
Explanation of any answers and additional evidence: The practice's significant event overview system identified themes and demonstrated action taken and subsequent learning. All significant events were reported to NHS England South West Area Team.	

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

Event	Specific action taken
The safety of staff at Millbrook surgery had been threatened by a member of the public on three separate occasions.	Following the incidents, the practice took the following actions; • The branch was closed for one month • Higher security measures were implemented to include keypad entry into clinical areas and CCTV in communal areas. Security glass was placed at reception desk. • The practice updated the lone-working policy and changed the opening hours of the branch to ensure staff were not working alone at the branch.
A patient had contacted the practice as they had not been contacted regarding a two-week wait urgent referral. The practice had subsequently discovered the referral had been misplaced at the practice	The referral was immediately resubmitted, and the practice apologised to patient. The practice updated the referral process; rather than carrying a printed version from the GP to the secretary, the GPs now sent the secretaries an electronic task which created an audit trail to ensure further referrals were not mislaid.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: We saw examples of actions taken on recent alerts for example, regarding sodium valproate.	

Effective Rating: Requires Improvement

The practice was rated as requires improvement for providing Effective care and for the following population groups; People with long-term conditions, families, children and young people, working age people, people experiencing poor mental health. This was because the practice was not able to demonstrate how they had monitored how many patients had attended appointments to monitor long-term conditions and mental health. The practice was also not able to demonstrate how they had promoted the uptake of cancer screening and childhood immunisations. Older people and people whose circumstances may make them vulnerable were rated as good.

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 used digital services securely and effectively and conformed to relevant digital and information security standards.	Y

Explanation of any answers and additional evidence:

The practice offered enhanced services including minor injuries, minor surgery and dermatology. The dermatology service was offered in conjunction with consultants which meant patients in South East Cornwall were able to access treatment without referral to a hospital.

Two GPs at the practice had completed enhanced specialist training in dermatology and Ear Nose and Throat (ENT).

The practice had attained an Armed Forces Veteran friendly GP practice accreditation in September 2018.The practice identified military veterans in line with the Armed Forces Covenant 2014. This enabled priority access to secondary care to be provided to those patients with conditions arising from their service to their country.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHSBSA)	0.80	0.84	0.75	No statistical variation

Older people — Population group rating: Good

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.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication 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 found that the uptake of flu vaccines had been low during 2018 and had therefore increased the capacity and availability of appointments in 2019.
- There was a named GP lead for patients living in nursing or care homes locally. The GP regularly visited the homes to ensure all patients had up to date care plans in place.
- The practice met monthly with the local palliative care nurse and were co-located with the district nursing team which the practice found promoted proactive multi-disciplinary working to support patients.

People with long-term conditions

Population group rating: Requires Improvement

Findings

This population group was rated as requires improvement because the practice was not able to demonstrate how they had monitored how many patients had attended appointments to monitor long-term conditions between April 2017 and March 2019.

- 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.
- 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 atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan. The practice had appointment a respiratory practice nurse who was due to commence employment in December 2019 and undertake asthma and COPD reviews and clinics.

Diabetes Indicators	Practice unverified data	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	95%	78%	77%	N/A
Exception rate (number of exceptions).		21%	13%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) (QOF)	95%	80%	78%	N/A
Exception rate (number of exceptions).		14%	9%	N/A

	Practice unverified data	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) (QOF)	93%	82%	80%	N/A
Exception rate (number of exceptions).		17%	13%	N/A

Kernow Clinical Commissioning Group (CCG) told us that because the practice had changed the patient records software system, 2018/19 data had not been published.

The practice showed us unverified 2018/19 data, as outlined in the above table, which led improvement in achievement.

In response to lower than local and national average Quality and Outcomes Framework (QOF) attainment for diabetes indicators for 2017/18, the practice had worked with a diabetes consultant who visited the practice and participated in virtual diabetes clinics for patients.

The practice told us that because they had changed their patient records software system in April 2019, they were not able to access exception reporting QOF data for 2018/19.
Published data for 2017/18 data showed that exception reporting for all three diabetes indicators were higher than local and national averages. As outlined in the table above.

The practice was not aware that exception reporting for diabetes indicators were higher than local averages. However, following this inspection the practice had searched for how patient exception reporting had been coded during 2017/18 and 2018/19. The practice told us that they had discovered an error in data input; Patients at the practice were recalled for an appointment to undertake relevant health checks during their birth month. If patients had not booked an appointment one month after a second invitation was sent, they had been exception reported. This had not made allowances for patients who attended a health check appointment, required to monitor their long-term condition, at any other point during the financial year.

The practice told us that they planned to retrain administrators to ensure errors in exception reporting would not occur again in the future. However, the practice was not able to demonstrate how they had monitored if patients had attended health checks for long-term conditions.

Other long-term conditions	Practice unverified data	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) (QOF)	92%	75%	75%	N/A
Exception rate (number of exceptions).		10%	7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	96%	91%	90%	N/A
Exception rate (number of exceptions).		13%	11%	N/A

Kernow Clinical Commissioning Group (CCG) told us that because the practice had changed the patient records software system to a different provider, 2018/19 data had not been published.

The practice showed us unverified 2018/19 data, as outlined in the above table which led improvement in achievement.

The practice told us that because they had changed their patient records software system in April 2019, they were not able to access exception reporting QOF data for 2018/19.
Published data for 2017/18 data showed that exception reporting for asthma and COPD indicators were higher than local and national averages. For example;

- 32% of patients with of patients with asthma had an asthma review in the preceding 12 months had been exception reported, compared with the CCG average of 11% and the national average of 8%.
- 39% of patients with COPD who have had a review in the preceding 12 months had been exception reported, compared with the CCG average of 12% and the national average of 10%.

The practice told us that high levels of exception reporting had been due to an administration error and did not accurately reflect the percentage of patients who had been exception reported.
The practice told us that they planned to retrain administrators to ensure errors in exception reporting would not occur again in the future. However, the practice was not able to demonstrate how they had monitored if patients had attended health checks for long-term conditions.

Indicator	Practice unverified Data	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) (QOF)	96%	85%	84%	N/A
Exception rate (number of exceptions).		6%	4%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) (QOF)	95%	88%	87%	N/A
Exception rate (number of exceptions).		5%	6%	N/A

Any additional evidence or comments

Kernow Clinical Commissioning Group (CCG) told us that because the practice had changed the patient records software system to a different provider, 2018/19 data had not been published.

The practice showed us unverified 2018/19 data, as outlined in the above table which led improvement in achievement.

The practice told us that because they had changed their patient records software system in April 2019, they were not able to access exception reporting QOF data for 2018/19.
Published data for 2017/18 data showed that exception reporting for hypertension and AF indicators were higher than local and national averages. For example;

- 12% of patients with of patients with hypertension who had their blood pressure measured in the preceding 12 months had been exception reported, compared with the CCG average of 7% and the national average of 7%.
- 17% of patients with AF, with a record of a CHA2DS2-VASc score of 2 or more, were currently treated with anti-coagulation drug therapy, had been exception reported, compared with the CCG average of 5% and the national average of 4%.

The practice was not aware that exception reporting for hypertension and AF indicators were higher than local averages but told us this had been due to an administration error and did not accurately reflect the percentage of patients who had been exception reported.
The practice told us that they planned to retrain administrators to ensure errors in exception reporting would not occur again in the future. However, the practice was not able to demonstrate how they had monitored if patients had attended health checks for long-term conditions.

Families, children and young people

Population group rating: Requires Improvement

Findings

This population group was rated as Requires Improvement due to low childhood immunisations uptake.

- The practice had not met the minimum 90% target for three out of four childhood immunisation uptake indicators. The practice believed this was due to parents choosing not to immunise their children. The practice promoted the benefits of childhood immunisations opportunistically during consultations and through information available on their website or in the patient waiting area.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

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) (01/04/2018 to 31/03/2019) (NHS England)	73	80	91.3%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	79	93	84.9%	Below 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) (01/04/2018 to 31/03/2019) (NHS England)	80	93	86.0%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	80	93	86.0%	Below 90% minimum

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

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

This population group has been rated as requires improvement because data for cancer indicators were below local and national target. However, we did see evidence of good care;

- 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.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

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) (01/04/2017 to 31/03/2018) (Public Health England)	74.9%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	76.3%	75.7%	72.1%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	60.3%	60.4%	57.3%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	24.5%	62.7%	69.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	46.1%	52.1%	51.9%	No statistical variation

Any additional evidence or comments

The practice was aware that the uptake for the above indicators were below local and national averages. On inspection, the practice was unable to provide us with up to date data from Public Health England to demonstrate improvements. However, they were able to provide us with unverified 2018/2019 data from the Quality and Outcomes Framework (QOF) which showed:

- 88% of women eligible for cervical screening had been adequately screened within a specified period.
- 100% of patients with cancer had a patient review recorded within six months of the date of diagnosis.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- 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 reviewed young patients at local residential homes.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

This population group was rated as requires improvement because the practice was not able to demonstrate how they had monitored how many patients had attended appointments to monitor mental health between April 2017 and March 2019.

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services. A consultant psychiatrist visited the practice four times a year to see older patients experience mental health issues.

Mental Health Indicators	Practice unverified Data	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	94%	91%	90%	N/A
Exception rate (number of exceptions).		15%	13%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	67%	92%	89%	N/A
Exception rate (number of exceptions).		12%	10%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	95%	83%	84%	N/A
Exception rate (number of exceptions).		8%	7%	N/A

Any additional evidence or comments

Kernow Clinical Commissioning Group (CCG) told us that because the practice had changed the patient records software system to a different provider, 2018/19 data had not been published.

The practice showed us unverified 2018/19 data, as outlined in the above table which led improvement in achievement.

The practice told us that because they had changed their patient records software system in April 2019, they were not able to access exception reporting QOF data for 2018/19.
Published data for 2017/18 data showed that exception reporting for mental health indicators were higher than local and national averages. For example;

- 32% of patients with schizophrenia, bipolar affective disorder and other psychoses who had a care plan documented in the record, in the preceding 12 months, had been exception reported compared with the CCG average of 16% and the national average of 13%.
- 24% of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months, had been exception reported compared with the CCG average of 14% and the national average of 10%.
- 38% of patients diagnosed with dementia who had a face-to-face care plan review in the preceding 12 months, had been exception reported, compared with the CCG average of 7% and the national average of 7%.

The practice was not aware that exception reporting for mental health indicators were higher than local

averages but told us this had been due to an administration error and did not accurately reflect the percentage of patients who had been exception reported.

The practice told us that they planned to retrain administrators to ensure errors in exception reporting would not occur again in the future. However, the practice was not able to demonstrate how they had monitored if patients had attended health checks for mental health.

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 comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

The practice undertook an audit to see if clinicians were asking patients for valid consent. The practice selected four patients per clinicians throughout the months of September 2018 and February 2019 to see if consent had been accurately recorded. 100% of clinical intervention reviewed showed consent had been obtained and noted.

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. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	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
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	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.	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.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

The practice had an overview of necessary and specialist training. We saw that all staff were up to date with refresher training. Staff told us they had protected time to complete training.

We saw the practice undertook role specific inductions and staff received probation reviews after the first, second and sixth month, from the commencement of employment.

We saw that all staff had received an appraisal in the last 12 months.

Coordinating care and treatment

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

Indicator	Y/N/Partial
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
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
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other 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, tackling obesity.	Y
Explanation of any answers and additional evidence: Reception staff and administrators who answered telephone calls had been renamed 'patient advisors' and had received training to sign post patients more effectively to external services. From December 2019, two Primary Care Network (PCN) social prescribers would be working at the practices for two days per week. The social prescribers would be able to support patients with their holistic needs including social care and signposting to external and community services.	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	96%	94.0%	95.1%	No statistical variation

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
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y

Well-led Rating: Requires Improvement

The practice was rated as requires improvement for providing Well-led services. This was due to shortfalls regarding the effectiveness of governance systems and the management of risks and performance.

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
Explanation of any answers and additional evidence: The practice had recently restructured the workforce; A practice manager had been appointed in 2018 to support the business manager. In addition, an operations manager had been appointed through a promotion and the reception supervisor was now responsible for managing the reception team. All staff worked at both the branch and the location and changes were discussed during meetings and via emails. We saw the practice regularly held nurses and clinical team meetings; reception team and whole practice meetings; operational managers meetings and strategy meetings.	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
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
Explanation of any answers and additional evidence: The Practice's vision was to provide high quality clinical care for patients and to constantly seek opportunities to expand and develop the range of care services offered to patients.	

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's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Partial
Explanation of any answers and additional evidence: Eight out of 32 staff members had completed equality and diversity training. We saw that all new staff had read the equality and diversity policy and procedure during their induction.	

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

Source	Feedback
Staff interviews	Staff told us that mangers were approachable and responsive to concerns. Staff supported each other and worked as a team to support patients and deliver services.

Governance arrangements

There were some clear responsibilities, roles and systems of accountability to support good governance and management. However, other governance systems were ineffective.

	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

Explanation of any answers and additional evidence:
Policies and procedures were updated annually or more frequently if required. All policies were available to all staff on the practice's intranet.

We saw there was an overview system to review and audit governance and structures. However, there were some shortfalls in the overview of governance systems that had not been identified prior to our inspection. For example;

- The fire alarm system at Penntorr Health had not been tested each week in accordance to the practice's procedures.
- The practice's infection prevention and control audit had not identified that there were no general cleaning records for the branch, Millbrook Surgery.
- Not all Patient Group Directions (PGDs) used to administer medicines, had been signed by all staff from the date the PGD was valid from.

The practice used health and safety and human resources systems provided by an external company. The external company informed the practice regarding updates and changes to policies and procedures. The practice received annual visits from the external company to complete audits of all relevant system used at the practice to monitor health and safety and human resources.

Managing risks, issues and performance

There were processes for managing risks, issues and performance. However, there were shortfalls in relation to monitoring patients with long-term conditions and poor mental health.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	N
There was a systematic programme of clinical and internal audit.	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

Explanation of any answers and additional evidence: All partners and the practice manager had copies of the business continuity plan. The practice was not aware that exception reporting for mental health and long-term conditions indicators were higher than local averages. Following this inspection, the practice informed us that this had been due to an administration error and 2017/18 Quality and Outcomes Framework (QOF) data did not accurately reflect the percentage of patients who had been exception reported. The practice told us that they planned to retrain administrators to ensure errors in exception reporting would not occur again in the future. However, the practice was not able to demonstrate how they had monitored if patients had attended health checks for long-term conditions or mental health.

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 adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

If the practice offered online services:

	Y/N/Partial
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
Any unusual access was identified and followed up.	Y
Explanation of any answers and additional evidence: Patients were able to order repeat prescription and book appointments online. The practice was in the process of updating the practice's website which was due to be launched in December 2019. The new website would sign post patients to external services and provide health advise for minor ailments. Patients would also be able to submit non-clinical and clinical to staff at the practice. For example, requests for sick notes and test results could be filtered and assigned to the most appropriate team at the practice to fulfil.	

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

Explanation of any answers and additional evidence:

Changes were communicated to patients via the website, social media and information displayed in the waiting area.

The practice had an active Patient Participation Group (PPG) who last met in June 2019. The practice implemented changes received by patients. For example, following suggestions from the PPG, the practice had enlarged the size of the font used on the information television monitor in the patient waiting area; and now published 'did not attend' (DNA) data on the website.

We received 18 CQC comment cards, 17 of which were positive about the care and treatment received by patients. The negative comment card received was regarding access to routine appointments.

Feedback from Patient Participation Group.

Feedback
The PPG told us the group had formed in 2011 and had contributed to positive changes at the practice. The PPG had also been involved in gathering patient feedback and liaison with external services regarding the provision of social prescribing.

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

Explanation of any answers and additional evidence:

The practice had introduced a new triaging system which involved the duty GP sitting with administrators who were answering calls each morning.

The practice implemented a new patient records software system. One of the benefits of the new

software was that the practice was able to monitor the amount of routine appointments available and release more appointments as required, to meet the demand.

The practices telephone system was due to be upgraded by December 2019. The new telephone system would be able to record incoming calls for training purposes. The telephone system also connected with the practice's patient records software system and would be able to automatically update contact telephone numbers to patients' records.

Examples of continuous learning and improvement

The practice was a research and training practice. The research team consisted of two nurses who continuously engaged in research. The practice told us that patients were keen to engage in research trials and the work of the research team promoted positive outcomes for patients and informed a learning culture throughout the practice.

The practice told us that following the success of the dermatology service offered at the practice for patients within South East Cornwall, the practice was working with the Clinical Commissioning Group and Kernow Health CIC to develop new models of care to enable patients to access secondary health care services without having to travel to hospitals.

A practice nurse had been supported to complete their prescribing training and become an advanced nurse practitioner (ANP).

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for most 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 practices 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.