Care Quality Commission

Inspection Evidence Table

The Penryn Surgery (1-570770410)

The Penryn Surgery (Mawnan Smith Surgery 1-570804597)

The Penryn Surgery (Stithians Surgery 1-570804613)

Inspection date: 4 and 5 December 2018

Date of data download: **22 November 2018**

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Safe

Safety systems and processes

Safeguarding	Y/N
There was a lead member(s) of staff for safeguarding processes and procedures.	Yes
Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Policies were in place covering adult and child safeguarding.	Yes
Policies were updated and reviewed and accessible to all staff.	Yes
Partners and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs)	Yes
Information about patients at risk was shared with other agencies in a timely way.	Yes
Systems were in place to highlight vulnerable patients on record. There was a risk register of specific patients	Yes
Disclosure and Barring Service checks were undertaken where required	Yes
The practice used a read code to denote when a chaperone was present during an examination. The practice policy stated staff undertaking chaperone duties could only do so after having DBS checked and completed training. Three patient records documented this policy had been followed.	

Recruitment Systems	Y/N
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Yes
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Staff who require medical indemnity insurance had it in place	Yes

Explanation of any answers:

Employment policies covering recruitment, equal opportunities and anti- discrimination and disclosure and barring service (DBS) checks were in place. We looked at the disclosure and barring service written policy, which set out which staff roles were applicable for checks and the level to be undertaken (standard or enhanced).
There was a three-month probationary period for all new staff to ensure staff completed any necessary training and demonstrated the required competencies of their job. We saw scheduled one to one performance meetings with staff at least every six months thereafter.

We looked at two staff files and found documentation verifying checks undertaken. Induction, training and appraisal records were easy to find demonstrating a clear audit trail of the management of staff. A spreadsheet was held of Nursing and Midwifery Council (NMC) registration, revalidation and other qualifications held. Dates had been kept demonstrating an annual check of the NMC was done for all nursing staff. The practice had employed a pharmacist and held the same information on file. GP revalidation and appraisal information was held and monitored by the practice.

Named staff were responsible for managing any locum staff. We sampled two locum personnel files which demonstratedsystems in place ensured appropriate checks were undertaken, prior to any locum staff starting work at the practice. Locum staff were given a pack of guidance information and received the monthly staff newsletter to keep them appraised of changes at the practice.

Safety Records	Y/N
There was a record of portable appliance testing or visual inspection by a competent person Date of last inspection/Test: November 2018	Yes
There was a record of equipment calibration Date of last calibration: February 2018	Yes
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals	Yes
Fire procedure in place	Yes
Fire extinguisher checks	Yes

Fire drills and logs	Yes
Fire alarm checks	Yes
Fire training for staff	Yes
Fire marshals	Yes
Fire risk assessment Date of completion July 2018 for Penryn, Mawnan Smith and Stithians Surgeries.	Yes
Actions were identified and completed.	Yes
Additional observations: The Penryn Surgery fire risk assessment identified: fire doors being wedged open; adjustments needed on certain fire doors; missing or painted over intumescent strips in some doors and old smoke detectors required replacement. Records documented all recommendations had been completed The Mawnan Smith surgery fire risk assessment identified: fire notices needed to be displayed and include a fire evacuation point outside the building; weekly fire alarm checks to be recorded. Records showed these actions had been completed. The Stithian Surgery fire risk assessment identified: an external refuse enclosure needed to be re-sited away from the building; fire notices needed to be displayed and include a fire evacuation point outside the building; a hole in the ceiling needed to be filled and adjustments required to closing devices on some fire doors. Records showed these actions had been completed. A longer-term plan was in place to redecorate the premises removing wood chip paper as recommended but seen as low risk.	
Health and safety Premises/security risk assessment? Date of last assessment: September 2018	Yes
Health and safety risk assessment and actions Date of last assessment: September 2018	Yes
Additional comments: The action plan highlighted maintenance contracts were in place and annual risk assessments had been completed. Following the assessment, daily visual checks of the dispensary and reception were recorded with team leaders responsible for completing these.	

Infection control	**Y/N**
Risk assessment and policy in place Date of last infection control audit: November 2018 The practice acted on any issues identified Detail: Medical devices, such as 24-hour blood pressure monitoring machines required decontamination. The practice had implemented a labelling system after cleaning to show when the equipment was ready for use by the next patient. All clinical and reception staff had completed infection prevention training.	Yes

The arrangements for managing waste and clinical specimens kept people safe?	Yes

Explanation of any answers:

A nurse lead had responsibility for management of infection control systems, regularly carrying out audits throughout the year. These included a monthly environmental audit in conjunction with the contractor and sharps, waste and hand hygiene audits. Minor surgery infection rates for patients were closely monitored, found to be low and reported upon as a standing item at meetings with GPs.

The practice had a waste consignment contract which was valid. Outdoor containers were used to store clinical waste until collection were secure and in place at Penryn, Mawnan Smith and Stithians surgeries. Staff showed us clinical specimens awaiting collection were stored appropriately in a specimen refrigerator.

We looked at records showing the practice appropriately notified Public Health England (PHE) of any infectious illnesses.

Staff told us the paper waste system was reviewed before the General Data Protection Regulations (GDPR) came into force. A new paper shredder to GDPR standards was purchased and being used.

Risks to patients

Question	Y/N
There was an effective approach to managing staff absences and busy periods.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans were developed in line with national guidance.	Yes
Staff knew how to respond to emergency situations.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
In addition, there was a process in the practice for urgent clinician review of such patients.	Yes
The practice had equipment available to enable assessment of patients with presumed sepsis.	Yes
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Yes

Explanation of any answers:

The practice had a period of instability during the summer months due to staff illness, however staff interviewed told us this was well managed. The senior management team used this as an opportunity to review staffing resources, skill mix and cover for absence. GPs had a buddy who covered them if they were absent or on leave.

We saw sepsis and other assessment protocols to assess deteriorating patients in all clinical areas and in reception. Staff had been trained and equipped with the knowledge and skills to identify early indicators of ill health and to signpost patients to appropriate appointments with clinical staff. Staff described when to escalate a patient for urgent assessment either by a GP or hospital. There was equipment in doctor's bags and clinical rooms for assessment, including adult and child oximeters (to measure patient blood oxygen levels).

The duty GP list clearly set out cover ahead for several weeks in advance, with key peak times such as bank holidays already covered. Calls from patients were appropriately handled by reception staff and the duty GP who made the decision about visiting priorities for that day.

Information to deliver safe care and treatment

Question	Y/N
Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented.	Yes
The practice had a documented approach to the management of test results and this was managed in a timely manner.	Yes
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.	Yes

Explanation of any answers:

Clear systems were seen with named staff monitoring the workflow to ensure tasks were completed. A spreadsheet of referrals demonstrated letters were typed within 48 hours and sent electronically to secondary healthcare services. Staff told us GPs and practice nurses communicated when a referral letter needed to be prioritised as urgent. We observed a member of staff being asked to complete a referral, which was completed and sent electronically within an hour.

The practice had a buddy system providing GPs with protected time to deal with results. Pathology results and records followed the practice protocol, being dealt with appropriately and in a timely way. Clinical records demonstrated patients had been referred to secondary health services in a correct and timely manner.

Appropriate and safe use of medicines

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) NHS Business Service Authority - NHSBSA)	0.69	0.97	0.94	Comparable with other practices
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2017 to 30/09/2018) (NHSBSA)	7.6%	9.7%	8.7%	Comparable with other practices

Medicines Management	Y/N
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	Yes
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example audits for unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were systems for the safe ordering, checks on receipt, storage, administration, balance checks and disposal of these medicines in line with national guidance.	Yes
Up to date local prescribing guidelines were in use.	Yes
Clinical staff were able to access a local microbiologist for advice.	Yes
For remote or online prescribing there were effective protocols in place for identifying and verifying the patient in line with General Medical Council guidance.	Yes
The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.	Yes
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Yes
There was medical oxygen on site.	Yes
The practice had a defibrillator.	Yes
Both were checked regularly and this was recorded.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	Yes

Explanation of any answers:

The practice followed the same procedures across all three locations at Penryn, Mawnan Smith and Stithians Surgeries. We saw several examples of these:

- All three sites had an emergency grab bag that was secure with tamper proof seals.
- Weekly checks took place of the equipment and a register of expiry dates for medicines was held showing all were in date.
- Staff responsible for checking equipment told us the practice followed resuscitation council guidelines to review the contents of emergency bags, anaphylaxis kits and equipment. Staff told us the contents was determined by risk and services delivered on the site. For example minimal interventions took place with patients at Mawnan Smith surgery so the emergency bags did not include medicines used for emergencies associated with contraceptive coil

fitting as this was not done there.

Dispensing practices only	Y/N
There was a GP responsible for providing effective leadership for the dispensary.	Yes
Access to the dispensary was restricted to authorised staff only.	Yes
The practice had clear Standard Operating Procedures for their dispensary staff to follow.	Yes
The practice had a clear system of monitoring compliance with Standard Operating Procedures.	Yes
Prescriptions were signed before medicines were dispensed and handed out to patents. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Yes
If the dispensary provided medicines in weekly or monthly blister packs (Monitored Dosage Systems) there were systems to ensure appropriate and correct information on medicines were supplied with the pack.	Yes
Staff were aware of medicines that were not suitable for inclusion in such packs and had access to appropriate resources to identify these medicines. Where such medicines had been identified staff provided alternative options that kept patients safe.	Yes
The home delivery service, or remote collection points, had been risk assessed (including for safety, security, confidentiality and traceability).	Yes
Information was provided to patients in accessible formats e.g. large print labels, braille labels, information in variety of languages etc.	Yes
There was the facility for dispensers to speak confidentially to patients and protocols described process for referral to clinicians.	Yes

Track record on safety and lessons learned and improvements made

Significant events	Y/N
There was a system for recording and acting on significant events	Partial
Staff understood how to report incidents both internally and externally	Yes
There was evidence of learning and dissemination of information	Partial
Number of events recorded in last 12 months.	6
Number of events that required action	6

Any additional evidence
We spoke with the lead GP about the system for recording and acting on significant events (SEAs). The practice recognised the number of SEAs for the size and complexity of the practice was lower than expected. This GP had identified the SEA process needed to be reviewed and awareness raised across all staff groups to increase reporting, analysis and shared learning from such events. Incidents had been discussed at clinical meetings where all GPs, the pharmacist, the emergency care practitioner, nursing team and practice manager attended.

We looked at the records for all six SEAs and found actions had taken place but this was not consistently recorded. We focussed on three SEAs, which had been appropriately investigated and we observed action plans had been evidenced as completed.

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

Event	Specific action taken
Failure of vaccines fridge at Mawnan Smith Surgery	During routine daily fridge temperature checks it was noted there had been a fluctuation of temperature, which was of concern. Nursing staff reported this and following unsuccessful repair a new fridge was immediately purchased. Appropriate advice was taken and vaccines disposed of where needed for patient safety. The event was discussed as the event occurred and more formally at clinical meetings.
A patient had not had a repeat **prostate-specific antigen** (**PSA**) test used to detect cancer	When the patient alerted practice the PSA test was completed leading to secondary care referral being made. A new system was put in place with a prompt added to patient records to ensure future tests were completed on time. The practice then carried out an audit of all patients at risk to provide assurance that they had received appropriate screening, referred and monitored where needed.
An optician recommended a patient be referred for further investigations which was not completed	The error was recognised when the patient contacted the practice as they had not received a hospital appointment come. We saw evidence of duty of candour being followed with a written apology being sent to the patient and confirmation that a referral had been made.

Safety Alerts	Y/N
There was a system for recording and acting on safety alerts	Yes
Staff understand how to deal with alerts	Yes

Comments on systems in place:

The practice had a policy in place and advice from national safety alerts had been acted on. Safety Alerts were discussed at clinical meetings, the daily huddles and communicated to all staff by email. Actions were recorded on a spreadsheet and monitored as having been completed. For example; a recent alert regarding had been received regarding the time taken for blood to clot when) testing with a specific machine. In response, an audit had been completed to provide assurance of accuracy and validity of results to promote patient safety.

Medicines safety alerts had been actioned and were overseen by the practice pharmacist. For example; related to sodium valproate medicine use for epilepsy. In response female patients who had been prescribed sodium valproate had been given additional advice and their prescriptions reviewed..

Any additional evidence
Explanation of any answers: The practice used an electronic prescribing system, enabling patients to have their medicines dispensed from a pharmacy of their choice. The practice had three dispensaries based at Penryn, Mawnan Smith and Stithians surgeries for patients who were eligible to use this service. All three dispensaries were inspected. Penryn Surgery owned two additional pharmacies one based in the building and the other in the town of Penryn for patients who did not qualify for dispensing services. We did not inspect these pharmacies as the Care Quality Commission (CQC) is not responsible for regulating them. Since the last inspection, a practice based pharmacist had been employed by the practice. The pharmacist met with patients reviewing their medicines with them. Additional duties included carrying out audits and searches on receipt of any medicines alerts or optimisation team requests and responsibility for action and follow up. The medicines technician assisted with the recall system, monitoring patients on high risk medicines such as lithium and warfarin. We reviewed two records for patients who were on methotrexate (a high-risk medicine) and saw they had regular blood tests for safety. Governance systems were in place with monthly audits being run to check patients were appropriately monitored with performance being reported at the practice meeting for GP partners to review. Medicines requiring refrigeration were stored appropriately on and off site with twice daily checks being completed. Staff responsible for checking the equipment described the process. All staff understood the safe temperature range which medicines needed to be stored at and understood when to escalate any concerns to their line manager. The practice had dataloggers to ensure refrigerators were operating within a safe temperature range to store vaccines safely. Records demonstrated these were also calibrated annually and daily temperature checks completed. Nursing staff verified there was a lockable portable vaccines refrigerator used for home visits. A risk assessment was carried out to identify any potential hazards during transportation, put measures in place to reduce these and set out the arrangements for calibration of the refrigerator. Calibration and electronic records demonstrated the equipment was maintained and regularly checked when in use. Since the last inspection, the practice had employed an eldercare nurse. During the winter months, outreach flu vaccination was carried out during home visits to housebound patients.

Effective

Effective needs assessment, care and treatment

Prescribing				
Indicator	**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) (01/10/2017 to 30/09/2018) (NHSBSA)	0.57	0.92	0.81	Comparable with other practices

People with long-term conditions

Diabetes Indicators				
Indicator	**Practice performance**	**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 (01/04/2017 to 31/03/2018) (QOF)	90.9%	83.8%	78.8%	Variation (positive)
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	29.5% (221)	19.2%	13.2%	
Indicator	**Practice performance**	**CCG average**	**England average**	**England comparison**
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 (01/04/2017 to 31/03/2018) (QOF)	88.5%	79.9%	77.7%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	29.5% (221)	12.3%	9.8%	

Indicator	Practice performance	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 (01/04/2017 to 31/03/2018) (QOF)	92.4%	83.2%	80.1%	Variation (positive)
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	24.8% (186)	14.4%	13.5%	

Other long term conditions				
Indicator	**Practice**	**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 (01/04/2017 to 31/03/2018) (QOF)	80.0%	75.3%	76.0%	Comparable with other practices

QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	36.1% (487)	11.0%	7.7%	
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
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 (01/04/2017 to 31/03/2018) (QOF)	90.9%	90.3%	89.7%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	36.3% (113)	14.4%	11.5%	

Indicator	Practice	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 (01/04/2017 to 31/03/2018) (QOF)	88.6%	83.1%	82.6%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	13.4% (290)	5.3%	4.2%	
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
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 (01/04/2017 to 31/03/2018) (QOF)	85.4%	89.5%	90.0%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	3.3% (10)	6.8%	6.7%	

Any additional evidence or comments

Nursing staff managed patients with long term conditions and used all contacts with patients to provide education and reviews. The practice verified decisions to exception report (exclude a patient from being reviewed) were made by GPs for clinical reasons. If the rationale for exception reporting was due to dissent of the patient this was done at the end of the financial year after all options had been explored to engage the patient in the process through telephone calls, letters and any face to face contact. We looked at a sample of patient records for those coded as having a diagnosis with asthma. We found appropriate recall arrangements were in place and at least three attempts had been made to encourage the patient to attend for review. Staff explained there was a higher percentage of young adults registered with the practice whilst attending university. This could be challenging to monitor when a student did not notify the practice when they had left the area or registered with another practice. To address this issue, the practice had set up close links with the university welfare liaison lead and provided clinics onsite at the university campus for students.

Families, children and young people

Child Immunisation				
Indicator	**Numerator**	**Denominator**	**Practice %**	**Comparison to WHO target**
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018)(NHS England)	132	142	93.0%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	132	145	91.0%	Met 90% minimum (no variation)
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) (01/04/2017 to 31/03/2018) (NHS England)	133	145	91.7%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	131	145	90.3%	Met 90% minimum (no variation)

Any additional evidence or comments

To increase the uptake of children being immunised, the practice had a named member of staff who contacted parents directly to have a discussion with them after letters were sent out from Public Health England (PHE).

The practice held an immunisation event, with a children's entertainer to engage hard to reach families

who had not had their children vaccinated. The first event lead to seven children being vaccinated. Children were given a bag with presents for being immunised, making it a positive experience for them. The practice planned further such events and intended to hold these at the weekend.

Working age people (including those recently retired and students)

Cancer Indicators				
Indicator	**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) (01/04/2016 to 31/03/2017) (Public Health England)	74.5%	74.9%	72.1%	Comparable with other practices
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) **(PHE)**	78.3%	76.6%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)**(PHE)**	62.7%	60.7%	54.6%	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. **(PHE)**	48.9%	63.7%	71.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2016 to 31/03/2017) (PHE)	43.4%	51.1%	51.6%	Comparable with other practices

Any additional evidence or comments

We discussed patient uptake for cervical screening with the practice. In March 2018, the practice identified a coding error which had exempted some women from being screened. This was corrected quickly to ensure women were followed up with an offer of an appointment for screening. The practice shared with us unpublished data for 2018/19 up to December 2018. This showed the practice was on target to achieve over 80% by the end of the year. The practice used every opportunity to engage women in the cervical screening (CVS) programme. Information about cervical screening was on the practice website and screens in waiting rooms.

A practice nurse was responsible for managing annual health reviews for patients with learning disabilities. The practice worked closely with learning disability nurse specialist, who provided support for female patients with a learning disability. Patients were invited to attend for cervical screening unless there was a clinical reason for this not to be done. The practice used easy read information about the screening programme where needed by the patient

Staff told us all patients with a cancer diagnosis were offered an open appointment with the lead practice nurse, to ensure patients received the support they needed. A monthly list of patients needing follow up was seen, which had due by dates for completion. The nurse explained these were telephone reviews so the patient could avoid having to travel during their recovery. The practice worked in conjunction with the hospice and palliative care nurses in the locality.

People experiencing poor mental health (including people with dementia)

Mental Health Indicators				
Indicator	**Practice**	**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 (01/04/2017 to 31/03/2018) (QOF)	94.2%	92.9%	89.5%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	53.6% (60)	16.5%	12.7%	
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	91.9%	90.9%	90.0%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	44.6% (50)	14.1%	10.5%	
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	71.9%	83.1%	83.0%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	5.0% (5)	7.4%	6.6%	

Any additional evidence or comments

We looked at a sample of patient records and discussed these with GPs. The practice verified decisions to exception report (exclude a patient from being reviewed) were made by GPs for clinical reasons. In the sample we saw some patients were under secondary care services, being regularly reviewed by the mental health team. The practice had carried out a review of the patient medicines in liaison with the mental health team. If the rationale for exception reporting was due to dissent of the patient this was done at the end of the financial year after all options had been explored to engage the patient in the process through telephone calls, letters and any face to face contact.

Monitoring care and treatment

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	-	-	-
Overall QOF exception reporting (all domains)	13.7%	6.7%	5.8%

Coordinating care and treatment

Indicator	Y/N
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Yes

Helping patients to live healthier lives

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)	92.2%	94.0%	95.1%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	1.0% (39)	1.1%	0.8%	

Consent to care and treatment

Description of how the practice monitors that consent is sought appropriately
Staff were able to explain the consent process and showed us templates on the patient record system. This included a checklist for when an Independent Mental Capacity Advocate (IMCA) was involved in making a best interest decision for a patient. Three sets of patient records reviewed contained appropriate notes and evidence of referrals made in a timely way.

Caring

Kindness, respect and compassion

CQC comments cards	
Total comments cards received	3
Number of CQC comments received which were positive about the service	3
Number of comments cards received which were mixed about the service	0
Number of CQC comments received which were negative about the service	0

Examples of feedback received:

Source	Feedback
For example, comments cards, NHS Choices	Patients comments highlighted staff were kind, caring and treated them with respect.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology has changed in 2018. This means that we cannot be sure whether the change in scores was due to the change in methodology, or was due to a genuine change in patient experience.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
20303	283	112	39.6%	0.55%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)	88.7%	92.6%	89.0%	Comparable with other practices
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very	89.7%	92.3%	87.4%	Comparable with other practices

Indicator	Practice	CCG average	England average	England comparison
good at treating them with care and concern (01/01/2018 to 31/03/2018)				
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	96.8%	96.9%	95.6%	Comparable with other practices
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	91.6%	89.2%	83.8%	Comparable with other practices

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Yes

Date of exercise	Summary of results
2018	The Friends of Penryn Surgery assisted the practice in undertaking the annual survey with 420 patients responding to it. Overall a high degree of satisfaction was expressed about the services and running of the practice.

Involvement in decisions about care and treatment

Examples of feedback received:

Source	Feedback
Interviews with patients	We spoke with nine patients in the waiting room who told us they felt listened to. They praised the practice staff who said they were treated with respect as a person.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	98.2%	95.8%	93.5%	Comparable with other practices

Question	Y/N
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in easy read format.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified	The practice had identified 0.8% (173) of the total patient population of 20238 at Penryn Surgery as being carers. The practice demographic had a higher percentage of younger patients registered whilst at University in the town.
How the practice supports carers	The practice used every opportunity to identify carers. Examples seen included a survey used for every patient attending the flu clinics to identify unknown carers. The new patient registration pack asked patients to identify themselves as a carer and clinical staff told us they asked patients during consultations. The Elder Care nurse monitored patients on the frailty register for vulnerable patients, which enabled the practice to identify any carers unknown to the practice and provide support for them also. Carers were signposted to support services, such as live well events taking place regularly in the community. Carers were offered flu vaccination. GPs triaged all requests for appointments and made reasonable adjustments for length of time and timing of these to meet patient needs.
How the practice supports recently bereaved patients	A GP or other key staff member would contact the family to offer support. The practice could also signpost patients to voluntary or charitable organisations who could offer support and advice.

Privacy and dignity

Question	Y/N
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Yes

	Narrative
Arrangements to ensure confidentiality at the reception desk	Staff were observed to be discreet when checking patients in for their appointments. Signs seen in the waiting rooms at Penryn, Stithians and Mawnan Smith surgeries advised patients there was a private room available should they wish to discuss any matter in private.

Question	Y/N
Consultation and treatment room doors were closed during consultations.	Yes
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes

Examples of specific feedback received:

Source	Feedback
CQC feedback cards	Three patients completed comment cards at Penryn Surgery.
Patients interviewed	We spoke with nine patients at Penryn Surgery, all of whom said staff treated them with respect. Staff were described as being friendly.
Patient participation representatives	Patients told us the staff were very good in all three surgeries managed by the practice. They told us they did not feel rushed when in an appointment with a GP. Patients said GPs spent time explaining treatment options or medications so they would understand why they are having the medication and what the side effects/benefits were.
Practice patient surveys	The practice provided results of surveys carried out every year since 2012. The results showed a trajectory of improvement. In 2012, the practice survey found 88% of patients were satisfied with privacy and dignity and this had increased to 92% in the 2018 survey.

Responsive

Responding to and meeting people's needs

Practice Opening Times	
Day	**Time**
Monday	Penryn surgery 8am to 6.30pm Stithians surgery 8.30am to 5.30pm Mawnan smith 8.30am to 12.30pm (GP only) Penryn Campus 8.30am to 11.30am (GP only)
Tuesday	Stithians surgery 8.30 to 2pm Mawnan surgery 8.30 to 12.30 (nurse only) Penryn campus 8.30 to 11.30am (GP only)
Wednesday	Stithians surgery 8.30am to 4.30pm Mawnansmith 8.30am to 12.30am (GP only) Penryn campus 2pm to 4.30pm (GP only)
Thursday	Stithians surgery 8.30am to 2pm Mawnansmith 8.30am to 12.30pm (nurse only) Penryn campus 2pm to 4pm (GP only)
Friday	Stithians surgery 8.30am to 4.30pm Mawnan smith 8.30am to 12.30pm (GP only) Penryn campus 8.30am to 11.30am (GP only)

Appointments available	
	GP appointments – telephone, advanced booking (six weeks) and same day face to face

	consultations. Home visits on request are triaged by a GP. Nurse appointments – advanced booking Health Care Assistant appointments – advanced booking
Extended hours opening	
	Tuesday and Thursday - 7am to 8am (GP, Nurse and Healthcare Assistant appointments) Across Kernow, access to extended services was available at hubs based in Bodmin, Stratton, St Austell, Liskeard, Newquay, Falmouth and Truro. Staff at the practice directed patients to these access services with further information available on the practice website. Outside of these times patients are directed to contact the out of hour's service by using the NHS 111 number.

Any additional evidence
The branch clinic held at Falmouth University was run by a GP every weekday during term time. After registration day for new students, a nurse clinic was held for vaccinations for any young adults who had not yet been vaccinated. Increased education of tutors and information for students had been prioritised to make them aware of the timescales required for travel vaccinations prior to any field trips. The practice used SMS text messages on the day of the clinics to remind students to attend. The practice reviewed demand for onsite services and found the drop-in clinic was the most successful due to significant uptake.

Home visits	**Y/N**
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention	Yes

If yes, describe how this was done
The practice had employed an Elder Care nurse for nine hours per week to support vulnerable patients to help them avoid unplanned admissions to hospital. The Elder Care nurse told us the practice had expanded the role, initially funded through NHS England as an unplanned admission avoidance measure. The practice held a list of vulnerable patients needing monitoring, which was reviewed by the nurse, lead GP and a named administrator. We saw 85 patients were on list for Penryn practice, covering all three locations and were told this was increasing every month. Vulnerable patients had annual reviews of their long-term conditions such as diabetes and respiratory conditions done at home. They were offered flu vaccination as part of this service. The Elder care reviews completed often led to referral to other third sector agencies and examples were seen where the nurse had helped a patient access domiciliary dentistry and optician services. A traffic light system was used for patients denoting

their level of frailty and risk status enabling the team to prioritise proactive support for patients who were at risk.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
20303	283	112	39.6%	0.55%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	92.8%	96.1%	94.8%	Comparable with other practices
Any additional evidence or comments The practice carried out its own survey of patients every year, in addition to the national GP Survey. There was improved patient satisfaction seen in the results for 2017 (83%) and 2018 (92%) about the repeat prescription request system.				

Timely access to the service

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
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 (01/01/2018 to 31/03/2018)	79.8%	77.7%	70.3%	Comparable with other practices
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	80.4%	78.1%	68.6%	Comparable with other practices
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	80.6%	74.6%	65.9%	Comparable with other practices
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	84.9%	82.6%	74.4%	Comparable with other practices

Examples of feedback received from patients:

Source	Feedback
CQC comment cards	Three patients in comment cards gave positive feedback about access to services.
Patient interviews	Nine patients highlighted the practice was easily contactable and they were generally able to get an appointment when they wanted. Staff were described as supportive, particularly in promoting healthier living through regular review appointments.

Listening and learning from complaints received

Complaints	Y/N
Number of complaints received in the last year.	23
Number of complaints we examined	23
Number of complaints we examined that were satisfactorily handled in a timely way	Yes
Number of complaints referred to the Parliamentary and Health Service Ombudsman	Yes
Additional comments:	
Documents showed the practice reviewed complaints, identifying themes and patterns as part of the governance arrangements and shared this information with the patient participation group (PPG). We sampled two complaints received. The practice provided timely responses to patients, outlined the investigation of the complaint and outcome. We saw patients were sent an apology when things went wrong, demonstrating the practice adhered to the duty of candour requirements.	

Example of how quality has improved in response to complaints
We reviewed a complaint about the handling of a telephone patient contact, where a patient had described serious concerning symptoms. The practice had thoroughly investigated the matter and reviewed the reception care pathway providing additional training for staff about managing deteriorating patient needs. The practice was proactive in obtaining and acting feedback from patients to improve services. An example of this was patients wanted on the day urine testing and the practice set up an on the day 'sit and wait' appointment for any patient with a suspected UTI. Nursing staff managed the service and reported this was well used by patients in need of assessment. It was too early for the practice to audit the impact for patients of early diagnosis and treatment and avoidance of unplanned admissions resulting form.

Well-led

Leadership capacity and capability

Examples of how leadership, capacity and capability were demonstrated by the practice
Leaders were knowledgeable about issues and priorities relating to the quality and future of services. The leadership team understood the challenges and were addressing them. For example, working collaboratively with other practices within the area sharing staff resources such as an emergency care practitioner to do home visits allocated by the duty GP. Staff interviewed told us the GPs and practice manager were visible and approachable and this was reflected in 37 Care Quality Commission staff survey forms received. Staff responses demonstrated communication either informally, electronically or during staff meetings was good.

Any additional evidence
The practice has three registered locations with the Care Quality Commission. However, when we inspected we established that the practice runs one patient list from Penryn Surgery across all three sites. We advised the practice to submit application forms to cancel the two locations of Mawnan Smith and Stithians Surgeries as these were running as branch surgeries.

Vision and strategy

Practice Vision and values
The practice vision and values was to provide evidence based primary medical care delivered in a caring and patient driven way for the community. The strategy was in line with health and social care priorities across the local area. The practice worked with local GP practices, educational and community organisations to offer patients additional services including onsite services at Falmouth University and extended hours.

Culture

Examples that demonstrate that the practice has a culture of high-quality sustainable care
Some of the staff team, including leaders, rotated their working week across the three practice locations at Penryn, Mawnan Smith and Stithians Surgeries. This enabled opportunities to observe how systems and processes were being utilised across the group to maintain consistency.

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

Source	Feedback
CQC staff surveys	We received 37 completed surveys from staff working across all three registered locations (Penryn, Stithians and Mawnan Smith Surgeries) at this inspection. All of the surveys were positive about working at the practice, with opportunities for development, good support and openness. The majority included comments about feeling proud to work at the practice because it was patient focussed and everyone worked to improve the experience for the patient.
Nursing team	Staff explained reasonable adjustments were put in place for staff when they had periods of ill health. Long term staff working here, supported and encouraged to develop skills and promotion to more senior roles.
Dispensary team	Staff were positive across all three locations at Penryn, Stithians and Mawnan Surgeries. Appropriate staff development arrangements were in place including

	ongoing access to training, supervision (including assessment of competency) and support.

Governance arrangements

Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care.	
Practice specific policies	The practice had a common IT system across all three registered locations. Policies and procedures were available to all staff through this system; the staff we spoke with were aware of the policies, their location and the detail of what they should do in regard of the policies and procedures.
Other examples	The practice utilised a shared drive, with electronic records facilitating governance and quality improvement. An example seen was the practice had updated its hepatitis B protocol for employed patients requesting screening and vaccination. The reception protocol was updated to include a flow chart. We saw patient information provided advice about the immunisation schedule, bloods taken to check immunity and employer responsibility including payments. A template was created with pre-filled information and automatic tasks sent to the administrative team

	Y/N
Staff were able to describe the governance arrangements	Yes
Staff were clear on their roles and responsibilities	Yes

Managing risks, issues and performance

Major incident planning	Y/N
Major incident plan in place	Yes
Staff trained in preparation for major incident	Yes

Examples of actions taken to address risks identified within the practice

Risk	Example of risk management activities
Nationally reported high risk of poor mental health and suicide in student in higher education	The practice had reviewed its mental health services for young adults at University in Falmouth following an evidence based review about the increased risk of suicide in new students. Closer links were set up with the student welfare officer with regular meetings being held to share any concerns about student patients needing support. The practice carried out a recent audit to measure the impact of the improvements made. Before the change, the practice identified one to two patients per week with suicidal thoughts. By November 2018 the shared early identification approach had identified 28 young adults with suicidal thoughts, all of whom had support and monitoring in place.
Limited local and regional	The practice had responded to increasing numbers of patients

support for patients with gender dysphoria	presenting with gender dysphoria, for whom there were limited local and regional services available. The practice identified that some patients were turning to illicit and unsafe practices. An information pack had been developed for patients, including signposting to national support agencies, referral processes to the regional gender dysphoria clinic, transition and post-surgery health screening (female to male ongoing eligibility for breast and cervical screening).
Continuity of care for patients seen by the nursing team	The nursing team identified a potential gap in communications due to part-time working and working across the practice's three locations. We saw records of handover meetings completed. These were reviewed for trend and theme analysis every month by the lead nurse to ensure actions were identified, shared with the team and addressed. .

Any additional evidence
Five staff were approved and trained to carry out cervical screening. Appraisals identified staff who were interested in family planning and keen to pursue this as an area of expertise. Plans were in place to support staff to achieve this goal, by enabling them to complete an appropriate course. Only five nurses in the Kernow area had been approved and trained to undertake coil and implant fitting, one of whom was based at Penryn Surgery. A nurse led coil fitting clinic was run which targeted young adult women to improve female reproductive health awareness and reduce unplanned pregnancies. An audit found the uptake was lower than expected. Attendance had increased because of the changes made to run a well woman and cervical screening clinics at the same time.

Appropriate and accurate information

Question	Y/N
Staff whose responsibilities include making statutory notifications understood what this entails.	Yes

Any additional evidence
The registered manager GP had left the practice, but had not applied to the Care Quality Commission to cancel their registration. The practice manager had notified CQC about this matter. Another GP partner was in the process of obtaining all the documentation required to register with CQC. We discussed this issue, which was proving difficult to resolve as the current registered manager was uncontactable. It was agreed that CQC would initiate a process to cancel the registration enabling a new manager to apply.

Engagement with patients, the public, staff and external partners

Feedback from Patient Participation Group;

Feedback
We were unable to speak directly with a representative from the patient participation group (PPG) due to unforeseen circumstances at the time of the inspection. The practice demonstrated through minutes of meetings held a collaborative and close partnership with the PPG. We saw other evidence of listening and acting on patient feedback led to improvements with the online appointment system enabling patients to book same day appointments from 8am as well as advanced booking for appointments with GPs. A

bike rack for cyclists was fitted following a request from patients.

Any additional evidence
Penryn Surgery was responsive to patient feedback and was proactively trying to address any problems raised by patients about the quality services provided. The practice had undertaken a review of Patient Survey 2018 data which was carried out in March 2018 for all three registered locations (including Mawnan Smith and Stithians Surgeries) and also NHS choices website. The practice routinely obtained feedback from staff, patients and other stakeholders. Examples of systems used included: the 360-degree survey for individual staff to provide feedback about their practise and facilitate their own professional development. Written feedback requested from a nursing home where a weekly scheduled visit to review patients took place. We saw feedback received about two individual clinicians and also the care home visiting service, all of which were strongly positive.

Continuous improvement and innovation

Examples of improvements demonstrated as a result of clinical audits in past two years

Audit area	Improvement
Workflow management	The practice continually audited decision making for assurance of patient safety outcomes with the workflow document management. Decisions for handling incoming clinical documents processed by a team of trained, continually audited administrators were reviewed and found to be safe.
Urinary tract infection and treatment with antibiotic prophylaxis for greater than 6 months	As part of the antibiotic stewardship the practice took action as part of a locality driven audit. The context of the audit was set against the known risk of antibiotic resistance and national drive to reduce prescribing wherever possible. The practice carried out a search of all patients who were on long term antibiotic treatment to reduce the risk of urinary tract infections. Patients recalled for assessment and changes to treatment were made where clinically appropriate.
Appropriateness of inclusion on child safeguarding register	The safeguarding lead carried out three monthly searches of the child safeguarding register and reviewed entries to ensure information was still appropriate. Leading on from this the practice had developed a template for staff to use for child safeguarding information. Thisenabled easier searches to be made across all three registered locations at Penryn, Stithians and Mawnan Smith Surgeries.

Any additional evidence
Penryn Surgery is an approved training and teaching practice. GP registrars (to become qualified GPs) and ST1, ST2 and ST3 doctors (specialty training for doctors to build up their knowledge, clinical skills and professional approach) were able to have placements at the practice and be supported by an

approved trainer. GP educational meetings were held monthly at the practice, which all clinical staff were able to attend.

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 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 comparable, 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 comparable 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 Band	Z-score threshold
1	Significant variation (positive)	Z ≤-3
2	Variation (positive)	-3 < Z ≤ -2
3	Comparable to other practices	-2 < Z < 2
4	Variation (negative)	2 ≤ Z < 3
5	Significant variation (negative)	Z ≥3
6	No data	Null

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.

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:

http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease
- **PHE**: Public Health England
- **QOF**: Quality and Outcomes Framework (see https://qof.digital.nhs.uk/).
- **RCP**: Royal College of Physicians.
- **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.(See NHS Choices for more details).