

Care Quality Commission

Inspection Evidence Table

St Keverne Health Centre (1-564557563)

Inspection date: 14 March 2019

Date of data download: 06 March 2019

Overall rating: Good

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

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. | Yes |
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Yes |
| There were policies covering adult and child safeguarding. | Yes |
| Policies took account of patients accessing any online services. | Yes |
| Policies and procedures were monitored, reviewed and updated. | Yes |
| Policies were 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). | Partial |
| There was active and appropriate engagement in local safeguarding processes. | Yes |
| There were systems to identify vulnerable patients on record. | Yes |
| There was a risk register of specific patients. | Yes |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Yes |
| Staff who acted as chaperones were trained for their role. | Yes |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm. | Yes |
| Explanation of any answers and additional evidence: | |
| Two registered nurses had received training to level two in safeguarding children, which did not meet | |

| Safeguarding | Y/N/Partial |
|--|--------------------|
| current guidance – Intercollegiate document Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (January 2019). | |
| Recruitment systems | Y/N/Partial |
| 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. | Partial |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | Yes |
| Staff had any necessary medical indemnity insurance. | Yes |
| Explanation of any answers and additional evidence: The practice had responded to national guidance following the ongoing measles outbreak in the UK. Staff were asked to provide evidence of vaccination. However, we sampled files for staff whose role included reception duties and found the practice had not obtained information about other vaccination and immunity status as per Department of Health guidelines. | |
| 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: 26 May 2018 | Yes |
| There was a record of equipment calibration. Date of last calibration: 20 February 2019 | Yes |
| There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. | Yes |
| There was a fire procedure. | Yes |
| There was a record of fire extinguisher checks. Date of last check: 24 July 2018, a new carbon dioxide extinguisher was added to a computer room which had not previously had one in it. | Yes |
| There was a log of fire drills. Date of last drill: 5 October 2017 | Yes |
| There was a record of fire alarm checks. Date of last check: weekly 13 March 2019 | Yes |
| There was a record of fire training for staff. Date of last training: Variable dates of completion throughout 2018/19. | Yes |
| There were fire marshals. | Yes |
| A fire risk assessment had been completed. Date of completion: 9 January 2019 | Yes |
| Actions from fire risk assessment were identified and completed. | Yes |
| Explanation of any answers and additional evidence: | |

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| Safeguarding | Y/N/Partial |
|---------------------|--------------------|

Records demonstrated equipment was calibrated annually by an external specialist company. However, we found a GP had equipment used for measuring blood oxygen levels was last checked in 2017 and confirmed to have been missed during the 2018 calibration checks. This was immediately replaced with equipment calibrated within the last 12 months and arrangements made for it to be recalibrated.

The fire risk assessment was reviewed annually and in 2019 highlighted a fire drill was overdue and there were gaps in staff training. All staff had completed the online training course for 2018/19 and a planned drill was planned to take place within two weeks of the inspection.

The training matrix demonstrated most staff had completed online fire safety training on different dates throughout 2018/19 up to the point of the inspection. The practice manager had sent email prompts to staff who were overdue.

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| Health and safety | Y/N/Partial |
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| Premises/security risk assessment had been carried out. Date of last assessment: February 2015 | Yes |
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| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 19 April 2018 | Yes |
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Explanation of any answers and additional evidence:
Documentation demonstrated a history of reviews of all risk assessments being done. The last Health and safety risk assessment highlighted PAT testing of electrical equipment was overdue and records confirmed it was actioned.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

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| | Y/N/Partial |
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| There was an infection risk assessment and policy. | Yes |
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| Staff had received effective training on infection prevention and control. | Yes |
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| Date of last infection prevention and control audit: 13 March 2019 | |
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| The practice had acted on any issues identified in infection prevention and control audits. | Yes |
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| The arrangements for managing waste and clinical specimens kept people safe. | Yes |
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Explanation of any answers and additional evidence:
In the recent infection prevention and control (IPC) audit, the practice identified and actioned improvements. The action plan highlighted hand hygiene audits had fallen behind due to recruitment issues in the nursing team, which were now resolved. All staff requiring IPC training had completed this online.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

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| | Y/N/Partial |
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| There was an effective approach to managing staff absences and busy periods. | Yes |
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| There was an effective induction system for temporary staff tailored to their role. | Yes |
| Comprehensive risk assessments were carried out for patients. | Yes |
| Risk management plans for patients were developed in line with national guidance. | Yes |
| Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment. | Yes |
| Clinicians knew how to identify and manage patients with severe infections including sepsis. | Yes |
| Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients. | Yes |
| There was a process in the practice for urgent clinical review of such patients. | Yes |
| There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency. | Yes |
| There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance. | Yes |
| When there were changes to services or staff the practice assessed and monitored the impact on safety. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>Since the last inspection, the practice had encountered challenges recruiting suitably qualified and experienced nursing staff when retirements took place. Appraisals completed in December 2018 showed there was low levels of absence due to sickness. The practice had provided additional training for staff to facilitate skill mix, enabling receptionists to hold a due role as dispensers for the dispensary.</p> | |

Information to deliver safe care and treatment

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

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

Appropriate and safe use of medicines

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

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) (NHS Business Service Authority - NHSBSA) | 1.24 | 0.97 | 0.94 | No statistical variation |
| The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2017 to 30/09/2018) (NHSBSA) | 8.7% | 9.7% | 8.7% | No statistical variation |
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2018 to 30/09/2018) (NHSBSA) | 5.73 | 5.73 | 5.64 | No statistical variation |
| Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2018 to 30/09/2018) (NHSBSA) | 2.97 | 2.69 | 2.22 | No statistical variation |

Explanation of any answers and additional evidence:

The antibiotic prescribing policy provided guidance in line with national targets for antibiotic stewardship. An audit in August 2018 found prescribing of antibiotics was appropriately based on clinical need.

| Medicines management | Y/N/Partial |
|--|-------------|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | Yes |
| Blank prescriptions were kept securely and their use monitored in line with national guidance. | Yes |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Yes |
| The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review. | NA |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. | Yes |

| Medicines management | Y/N/Partial |
|--|--------------------|
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services. | Yes |
| There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. | Yes |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Yes |
| There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. | Yes |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance. | Yes |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | Yes |
| For remote or online prescribing there were effective protocols for verifying patient identity. | Yes |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates. | Yes |
| The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases. | Yes |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Yes |
| Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective. | Yes |

| Dispensary services (where the practice provided a dispensary service) | Y/N/Partial |
|--|--------------------|
| There was a GP responsible for providing effective leadership for the dispensary. | Yes |
| The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance. | Yes |
| Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency. | Yes |
| Prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions. | Yes |
| Medicines stock was appropriately managed and disposed of, and staff kept appropriate records. | Yes |
| Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective. | Yes |
| If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, | Yes |

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| and appropriate information was supplied to patients about their medicines. | |
| If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability. | Yes |
| Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence. | Yes |
| Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc. | Yes |
| There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians. | Yes |
| <p>Explanation of any answers and other comments on dispensary services:</p> <p>All patients registered at the practice were eligible to use the dispensary service. GPs told us over 8000 items were dispensed every month for patients.</p> <p>The delivery service risk assessment had been actioned, for example a Disclosure and Barring Service (DBS) check was obtained for the delivery service courier.</p> | |

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

| Significant events | Y/N/Partial |
|--|-------------|
| The practice monitored and reviewed safety using information from a variety of sources. | Yes |
| Staff knew how to identify and report concerns, safety incidents and near misses. | Yes |
| There was a system for recording and acting on significant events. | Yes |
| Staff understood how to raise concerns and report incidents both internally and externally. | Yes |
| There was evidence of learning and dissemination of information. | Yes |
| Number of events recorded in last 12 months: | 9 |
| Number of events that required action: | 9 |
| <p>Explanation of any answers and additional evidence:</p> <p>The practice reviewed clinical events through the complaint procedure. Letters, minutes of clinical meetings and emails clearly demonstrated how the matter was investigated, learning disseminated and outcomes communicated with patients. However, the practice recognised a system was needed to capture the analysis, action plan and any arrangements for follow up such as audit for assurance of embedded change and had implemented this before the inspection.</p> | |

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

| Event | Specific action taken |
|--------------------------|---|
| Delayed cancer diagnosis | The practice investigated concerns raised by a patient and provided a detailed response. A case review was held leading to the development of a protocol to follow up any patient who did not attend the practice for results. Any new cancer diagnoses were circulated so all staff were aware of a change in circumstances for a patient. |

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| Failure of vaccines fridge | Routine daily fridge temperature checks identified a significant fluctuation of temperature. A new fridge and internal temperature data logger was purchased. Vaccines were disposed of where needed for patient safety. The event was discussed as the event occurred and more formally at clinical meetings. |
|----------------------------|--|

| Safety alerts | Y/N/Partial |
|---|-------------|
| There was a system for recording and acting on safety alerts. | Yes |
| Staff understood how to deal with alerts. | Yes |
| Explanation of any answers and additional evidence: Safety alerts about appliances, prescribing and violent patients were actioned. The practice retention policy was to destroy the actioned alerts every three months. However, audit activities did provide evidence of other alerts being actioned over the previous three years, for example an alert about sodium valproate and potential risks to pregnant women. The practice recognised the system needed to be reviewed and set up a register to monitor all alerts, actions, audits and changes made. | |

Effective

Rating: 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. | Yes |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Yes |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Yes |
| Patients' treatment was regularly reviewed and updated. | Yes |
| There were appropriate referral pathways were in place to make sure that patients' needs were addressed. | Yes |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Yes |

| 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) (01/10/2017 to 30/09/2018) <small>(NHSBSA)</small> | 1.37 | 0.92 | 0.81 | 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.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks were offered to patients over 75 years of age.

Population group rating: **Good**

People with long-term conditions

Findings

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

| Diabetes Indicators | Practice | 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) <small>(QOF)</small> | 87.2% | 83.8% | 78.8% | No statistical variation |
| Exception rate (number of exceptions). | 11.8% (20) | 19.2% | 13.2% | 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 (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 85.4% | 79.9% | 77.7% | No statistical variation |
| Exception rate (number of exceptions). | 7.1% (12) | 12.3% | 9.8% | N/A |

| | Practice | 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) <small>(QOF)</small> | 86.9% | 83.2% | 80.1% | No statistical variation |
| Exception rate (number of exceptions). | 9.5% (16) | 14.4% | 13.5% | N/A |

| Other long-term conditions | 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) <small>(QOF)</small> | 77.5% | 75.3% | 76.0% | No statistical variation |
| Exception rate (number of exceptions). | 0 (0) | 11.0% | 7.7% | 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 (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 95.7% | 90.3% | 89.7% | No statistical variation |
| Exception rate (number of exceptions). | 2.8% (2) | 14.4% | 11.5% | N/A |

| 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) <small>(QOF)</small> | 81.7% | 83.1% | 82.6% | No statistical variation |
| Exception rate (number of exceptions). | 3.5% (19) | 5.3% | 4.2% | 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 (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 91.0% | 89.5% | 90.0% | No statistical variation |
| Exception rate (number of exceptions). | 2.2% (2) | 6.8% | 6.7% | N/A |

Any additional evidence or comments

The lead practice nurse had implemented active monitoring of the patient recall system. Proactive asthma reviews were done, with all patient contact being used to undertake these. Working patients were offered early and late appointments to facilitate uptake of asthma reviews. The practice shared unpublished data for 2018/19, which at the point of the inspection demonstrated no exception reports had been made for any patient on the asthma register demonstrating good outcomes for patients (Exception reporting excludes a patient from being reviewed for either clinical reasons or patient dissent).

Families, children and young people

Population group rating: Good

Findings

- Childhood immunisation uptake rates were mostly in line with the World Health Organisation (WHO) targets.
- 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.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- Young people could access services for sexual health and contraception. The practice was mindful of confidentiality issues being located in an isolated coastal area so worked in collaboration with a practice on the Western side of the Lizard Peninsular to deliver these services for young people.

| Child Immunisation | 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) <small>(NHS England)</small> | 23 | 24 | 95.8% | Met 95% WHO based target (significant variation positive) |
| 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) <small>(NHS England)</small> | 18 | 20 | 90.0% | 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) <small>(NHS England)</small> | 18 | 20 | 90.0% | 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) <small>(NHS England)</small> | 17 | 20 | 85.0% | Below 90% minimum (variation negative) |
|---|----|----|-------|--|

Any additional evidence or comments

World Health Organisation (WHO) targets were met except for the measles, mumps and rubella (MMR) immunisation given as a single dose. There were mitigating factors for the below average performance, which affected three out of 20 patients. The practice told us parents had chosen to dissent due to their views about the MMR vaccine. Staff demonstrated they used every opportunity to continue offering and educating families about the safety of the MMR vaccine to encourage uptake.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- 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) <small>(Public Health England)</small> | 72.8% | 74.7% | 71.7% | No statistical variation |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) <small>(PHE)</small> | 77.3% | 75.7% | 70.0% | N/A |
| Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) <small>(PHE)</small> | 62.2% | 60.4% | 54.5% | 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) <small>(PHE)</small> | 72.2% | 62.7% | 70.2% | 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) <small>(PHE)</small> | 40.7% | 52.1% | 51.9% | No statistical variation |

Any additional evidence or comments

Nursing staff supported hard to reach female patients, using every opportunity to engage women in the cervical screening programme, examples were: Information on the website and screens in waiting rooms raising awareness. Reminders on patient records prompting encouragement to set up an appointment. Longer appointments and pre-screening prescription for hormonal pessary for peri/menopausal women to reduce any discomfort.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- 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 held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- 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.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- 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.
- 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.

| Mental Health Indicators | 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) <small>(QOF)</small> | 100.0% | 92.9% | 89.5% | No statistical variation |

| | | | | |
|---|--------------|-------|-------|--------------------------|
| Exception rate (number of exceptions). | 0 (0) | 16.5% | 12.7% | 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 (01/04/2017 to 31/03/2018) (QOF) | 100.0% | 90.9% | 90.0% | No statistical variation |
| Exception rate (number of exceptions). | 0 (0) | 14.1% | 10.5% | 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 (01/04/2017 to 31/03/2018) (QOF) | 97.1% | 83.1% | 83.0% | Variation (positive) |
| Exception rate (number of exceptions). | 10.3% (4) | 7.4% | 6.6% | N/A |

Any additional evidence or comments

The practice was proactive in reviewing vulnerable patients with mental health needs, doing this every quarter in conjunction with the community matron. This meant patients with mental health needs were well cared for.

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.

| Indicator | Practice | CCG average | England average |
|---|----------|-------------|-----------------|
| Overall QOF score (out of maximum 559) | 541.9 | 548.1 | 537.5 |
| Overall QOF exception reporting (all domains) | 4.7% | 6.7% | 5.8% |

| | Y/N/Partial |
|---|-------------|
| Clinicians took part in national and local quality improvement initiatives. | Yes |
| The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements. | Yes |

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

Minor surgery audit – completed annually and in 2019 concluded patient satisfaction remained high. This was a small sample of nine patients and a more systematic review of minor surgery outcomes should be done. A proforma was developed facilitating systematic review of patient outcomes post procedure

Lorazepam prescribing audit – the audit verified there was appropriate contact and regular planned reviews of residents living in residential care. It provided assurance of appropriate protocols being in place for administration of lorazepam in the two care homes supported by the practice. Initial diversional activity and low stimulus environments were encouraged by GPs to help manage acutely agitated and aggressive

patients before a short course of lorazepam was prescribed.

Any additional evidence or comments

A high risk medicine audit was carried out in 2019, which provided assurance of safe prescribing and monitoring of patients taking lithium. A new recall system and a written protocol ensured improvement to patient care, specifically patient safety. The practice had seen an increase from 60% to 100% of patients having regular blood tests for kidney function, thyroid function and calcium levels. Three monthly measurement of serum lithium levels remained at 100%. With respect to effectiveness of treatment, both at baseline and review 100% of patients had a lithium level within their therapeutic range.

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. | Yes |
| The learning and development needs of staff were assessed. | Yes |
| The practice had a programme of learning and development. | Yes |
| Staff had protected time for learning and development. | Yes |
| There was an induction programme for new staff. | Yes |
| Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015. | Yes |
| Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation. | Yes |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | Yes |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Yes |

Coordinating care and treatment

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

| Indicator | Y/N/Partial |
|--|-------------|
| 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) | Yes |
| 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. | Yes |
| Care was delivered and reviewed in a coordinated way when different teams, services or | Yes |

| | |
|--|-----|
| organisations were involved. | |
| Patients received consistent, coordinated, person-centred care when they moved between services. | Yes |
| For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services. | NA |

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

| | | | | Y/N/Partial |
|---|-------------|-------|-------|--------------------------|
| The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers. | | | | Yes |
| Staff encouraged and supported patients to be involved in monitoring and managing their own health. | | | | Yes |
| Staff discussed changes to care or treatment with patients and their carers as necessary. | | | | Yes |
| The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity. | | | | Yes |
| 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) <small>(QOF)</small> | 94.1% | 94.0% | 95.1% | No statistical variation |
| Exception rate (number of exceptions). | 0.7% (6) | 1.1% | 0.8% | N/A |

Consent to care and treatment

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

| | | | | Y/N/Partial |
|--|--|--|--|-------------|
| Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented. | | | | Yes |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. | | | | Yes |
| The practice monitored the process for seeking consent appropriately. | | | | Yes |

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

| | Y/N/Partial |
|---|-------------|
| Staff understood and respected the personal, cultural, social and religious needs of patients. | Yes |
| Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition. | Yes |

| CQC comments cards | |
|--|----|
| Total comments cards received. | 28 |
| Number of CQC comments received which were positive about the service. | 28 |
| Number of comments cards received which were mixed about the service. | 0 |
| Number of CQC comments received which were negative about the service. | 0 |

| Source | Feedback |
|-------------------|---|
| CQC comment cards | Patient feedback was strongly positive, describing St Keverne Health Centre as a safe service with caring staff who listen and act on their wishes. |

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 2903 | 222 | 122 | 55.1% | 4.20% |

| 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) | 95.8% | 92.6% | 89.0% | No statistical variation |
| 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 treating them with care and concern | 99.4% | 92.3% | 87.4% | Variation (positive) |

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| (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) | 100.0% | 96.9% | 95.6% | Variation (positive) |
| 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) | 96.6% | 89.4% | 83.8% | No statistical variation |

| Question | Y/N |
|---|-----|
| The practice carries out its own patient survey/patient feedback exercises. | No |

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

| | Y/N/Partial |
|---|-------------|
| Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given. | Yes |
| Staff helped patients and their carers find further information and access community and advocacy services. | Yes |

| Source | Feedback |
|---------------------------|---|
| Interviews with patients. | Patients were positive about their experiences at the practice. |

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) | 99.3% | 95.8% | 93.5% | No statistical variation |

| | Y/N/Partial |
|---|-------------|
| 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 other languages and 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 58 of patients as carers, which is 2% of the total number of patients registered with the practice. Any patients over 75 the practice gives them a form which asks whether they have a carer, power of attorney arrangements. |
| How the practice supported carers. | As a small practice, the staff knew patient needs very well and demonstrated anticipatory actions to reduce potential risks as patients became infirm or frail. The practice worked collaboratively with the community matron communicating increased risk and needs for patients and their carers. Carers were signposted to the Carers forum. We saw information in the waiting room advising patients of carer support groups. |
| How the practice supported recently bereaved patients. | The named GP telephoned bereaved family and carried out visits offering referrals for counselling and any other support needed. |

Privacy and dignity

The practice respected patients' privacy and dignity.

| | Y/N/Partial |
|--|-------------|
| Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. | Yes |
| 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 |
| There were arrangements to ensure confidentiality at the reception desk. | Yes |

Responsive

Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

| | Y/N/Partial |
|---|-------------|
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided. | Yes |
| The facilities and premises were appropriate for the services being delivered. | Yes |

| | |
|---|-----|
| The practice made reasonable adjustments when patients found it hard to access services. | Yes |
| The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice. | Yes |
| Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services. | Yes |
| Explanation of any answers and additional evidence: | |
| Services were set up to meet the needs of the local community: | |
| <ul style="list-style-type: none"> Nurses ran dedicated clinics for the management of chronic diseases covering hypertension, diabetes, asthma and COPD. Near patient testing was available for those taking warfarin, where results and dosing advice was all given during a consultation. Patients were able to avoid having to attend Helston Hospital, some distance away and only accessible by car. The practice had a higher than average number of patients over 65 years who needed specific help. Blister packs were filled by the dispensary for the administration of medications. Joint injections and minor surgery services were available on site reducing the need for elderly patients to travel to hospital outpatient appointments. The practice hosted monthly podiatrist/chiropractor clinics. Three staff were able to deliver 'SAVVY' services (Savvy Kernow provides information on young person friendly services for 13-19 year olds) signposting them to appropriate services in the area. On-line repeat prescription ordering service and bookable appointments for all patients. On-site physiotherapist one day per week for patients referred by their GP. Addiction drug and alcohol counselling service onsite weekly clinics weekly and counselling services under IAPT via Outlook Southwest. A travel clinic, stop smoking advice, emergency and general contraceptive services including coil fitting, and sexually transmitted infection screening. | |

| Practice Opening Times | |
|-------------------------|---|
| Day | Time |
| Opening times: | |
| Monday | 8am to 6.30pm* |
| Tuesday | 8am to 6.30pm* |
| Wednesday | 8am to 6.30pm* |
| Thursday | 8am to 6.30pm* |
| Friday | 8am to 6.30pm* |
| | *The surgery closes for administrative purposes between 1pm and 2pm every day. During this period telephones switch over to an answering service as per local agreement with NHS England. |
| Appointments available: | |
| Monday | 7am to 7.45am GP appointments for working |

| | |
|-----------|--|
| | <p>patients 7.30am to 7.45 am Nurse appointments for working patients 9.30am to 10.30am open surgery access for all patients. Patients are seen throughout the day. Telephone appointments with GP by arrangement</p> |
| Tuesday | 9.30am to 10.30am open surgery access for all patients. Patients are seen throughout the day. Telephone appointments by arrangement. |
| Wednesday | 9.30am to 10.30am open surgery access for all patients. Patients are seen throughout the day. Telephone appointments by arrangement. |
| Thursday | 9.30am to 10.30am open surgery access for all patients. Patients are seen throughout the day. Telephone appointments by arrangement Late GP appointments up to 8pm. |
| Friday | 9.30am to 10.30am open surgery access for all patients. Patients are seen throughout the day. Telephone appointments by arrangement. |
| | 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. |

National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 2903 | 222 | 122 | 55.1% | 4.20% |

| 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) | 100.0% | 96.2% | 94.8% | Variation (positive) |

Older people

Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

- There was a **weekly medicines delivery service** for housebound patients.

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Good

Findings

- Late appointments were available until 8pm on a Thursday, for any patients including school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- **Women were able to access contraception such as coils. Any patients needing implants were referred to Helston Health Centre.**
- **The practice is an approved SAVVY service for young patients providing access to sexual health and contraceptive advice.**

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 6.30pm Monday to Friday. Extended hours opening was held on twice a week providing early and late appointments (Monday 7am and Thursday until 8pm) Pre-bookable appointments were also available to all patients at additional locations within the area with neighbouring practices.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice was aware of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. St Keverne Health Centre is a small practice with 7 patients with learning disabilities.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

People were able to access care and treatment in a timely way.

National GP Survey results

| | Y/N/Partial |
|--|-------------|
| Patients with urgent needs had their care prioritised. | Yes |
| The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. | Yes |
| Appointments, care and treatment were only cancelled or delayed when absolutely necessary. | Yes |

| 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) | 96.8% | N/A | 70.3% | Significant Variation (positive) |
| 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) | 83.4% | 78.1% | 68.6% | No statistical variation |
| 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) | 80.1% | 74.6% | 65.9% | No statistical variation |
| The percentage of respondents to the GP patient survey who were satisfied with the | 79.9% | 82.7% | 74.4% | No statistical variation |

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------|
| type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018) | | | | |

Any additional evidence or comments

In line with national policy developments the practice has worked collaboratively with other nearby practices to improve patient access to appointments. Patients gave positive feedback about this in the CQC comment cards and were able to access early and late face to face appointments, as well as a range of online services and telephone appointments.

| Source | Feedback |
|-------------------|--|
| CQC comment cards | All 28 patients responding in CQC comment cards were positive about the service, describing it as 'exceptional' and 'excellent'. |
| IwantGreat Care | Since the last inspection, the practice had received 75 strongly positive reviews on this website. Staff were described as caring and thorough. Patients wrote about being given time, respect and feeling involved in their healthcare. |

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

| Complaints | |
|--|---|
| Number of complaints received in the last year. | 2 |
| Number of complaints we examined. | 2 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 2 |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman. | 0 |

| | Y/N/Partial |
|---|-------------|
| Information about how to complain was readily available. | Yes |
| There was evidence that complaints were used to drive continuous improvement. | Yes |
| Explanation of any answers and additional evidence: The complaint procedure stipulated patients should receive a response within two weeks and aimed for local resolution before escalation. We found this was followed with both complaints reviewed. | |

Example(s) of learning from complaints.

| Complaint | Specific action taken |
|-----------|-----------------------|
|-----------|-----------------------|

| | |
|---|---|
| Recurrent cancer diagnosis not identified due to late presentation of patient with concerns | A full clinical review took place, which identified a gap in following up patients who did not attend (DNA) when appointments were made. A DNA protocol was designed whereby patients were followed up by their GP if they did not attend an appointment within a given period of time. |
|---|---|

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels to deliver high quality sustainable care.

| | Y/N/Partial |
|---|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | Yes |
| They had identified the actions necessary to address these challenges. | Yes |
| Staff reported that leaders were visible and approachable. | Yes |
| There was a leadership development programme, including a succession plan. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>St Keverne Health Centre is located in an isolated coastal area, some considerable distance away from the nearest acute secondary service. GPs told us whilst the number of registered patients remained static since the last inspection, the level of frailty had increased as patients aged. The practice had more than double the national average of patients over 65 years of age.</p> <p>Several changes within the team created challenges during this period. Recruitment of suitably qualified and experienced nursing staff within the context of national recruitment shortages had been overcome. Examples of staff development seen were:</p> <ul style="list-style-type: none"> • Practice nurse new to the role was funded and in the process of completing a degree in practice nursing through the local university. • Healthcare assistant provided specialist training enabling them to undertake extended role, which included: simple wound management; INR near patient testing; foot checks for diabetic patients; health screening and ear irrigation. • GPs had special interest areas such as minor surgical procedures and regularly completed updates as assurance of their competency. | |

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. | Yes |
| There was a realistic strategy to achieve their priorities. | Yes |
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | Yes |
| Staff knew and understood the vision, values and strategy and their role in achieving | Yes |

| | |
|--|-----|
| them. | |
| Progress against delivery of the strategy was monitored. | Yes |
| Explanation of any answers and additional evidence: All of the staff interviewed and those responding in six CQC staff survey forms told us the focus of the practice was to deliver high quality patient focussed care. Feedback from patients, in CQC comment cards (28), IwantGreat Care (69 reviews) and the GP patient survey results all demonstrated the practice achieved high patient satisfaction. Individual comments highlighted all staff were knowledgeable and caring about patients and the needs of their extended family. | |

Culture

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

| | Y/N/Partial |
|--|-------------|
| There were arrangements to deal with any behaviour inconsistent with the vision and values. | Yes |
| Staff reported that they felt able to raise concerns without fear of retribution. | Yes |
| There was a strong emphasis on the safety and well-being of staff. | Yes |
| There were systems to ensure compliance with the requirements of the duty of candour. | Yes |
| The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy. | Yes |
| Explanation of any answers and additional evidence: Staff survey responses and verbal comments were positive about the culture, which was said to focus on quality improvement through support and learning activities. | |

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

| Source | Feedback |
|---------------------------|--|
| CQC staff feedback survey | Staff verified there was good team work and rapport with patients and their families. They were encouraged to work within their skillset and develop through training. |
| Staff interviews | Six staff said they were proud to work at the practice. Staff described an open culture, where learning was supportive and improvements made. |

Governance arrangements

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

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

Explanation of any answers and additional evidence:
 The practice reported any serious incidents or concerns to NHS England, which were reviewed and action taken where needed.

Staff held lead roles, for example for supervision of staff groups such as the nursing team, key areas of practice including safeguarding, infection prevention and control and quality improvement.

Managing risks, issues and performance

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

| | Y/N/Partial |
|--|-------------|
| There were comprehensive assurance systems which were regularly reviewed and improved. | Yes |
| There were processes to manage performance. | Yes |
| There was a systematic programme of clinical and internal audit. | Yes |
| There were effective arrangements for identifying, managing and mitigating risks. | Yes |
| A major incident plan was in place. | Yes |
| Staff were trained in preparation for major incidents. | Yes |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Yes |
| Explanation of any answers and additional evidence: | |
| Staff were able to describe quality improvement systems, such as reflecting upon complaints and other feedback from patients. Staff described managers as being fair, supportive and encouraging staff to deliver high standards of care. From the discussions, staff understood and were actively involved in developing and reviewing protocols throughout the year resulting from learning from significant events, complaints and networking with other professional groups in the locality. | |

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. | Yes |
| Performance information was used to hold staff and management to account. | Yes |
| Our inspection indicated that information was accurate, valid, reliable and timely. | Yes |
| There were effective arrangements for identifying, managing and mitigating risks. | Yes |
| Staff whose responsibilities included making statutory notifications understood what this entails. | Yes |
| Explanation of any answers and additional evidence: | |
| The practice had reviewed its governance arrangements for: | |

- Monitoring the handling of all safety alerts – a protocol was being written up and historical information to be held in a spreadsheet showing accountability, actions and links to audit.
- Responding to requests for a medical report – following a complaint, the practice had created a protocol which took account of General Data Protections Regulation requirements. A checklist was used to ensure any reports completed related to the correct patient.

Engagement with patients, the public, staff and external partners

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

| | Y/N/Partial |
|--|-------------|
| Patient views were acted on to improve services and culture. | Yes |
| Staff views were reflected in the planning and delivery of services. | Yes |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Yes |

Feedback from Patient Participation Group.

| Feedback |
|--|
| At the last inspection, CQC suggested the practice should improve engagement by setting up a patient participation group. A patient had indicated interest in taking on the role of chair-person but further work on setting up the PPG had been put on hold due to unforeseen circumstances. The practice had more than double the number of older patients, many of whom were housebound, did not use new technology and were hard to reach for formal feedback. However, the practice utilised any feedback received from patients via the community matron, their families and friends or direct during home visits to improve their experience. |
| The practice had a 'Friends of St Keverne Health Centre' which held three meetings a year. The practice used the annual general meeting to ask patients for feedback. The group had purchased equipment through fundraising, for example new Dopplers (a specialised listening device), including one to read foetal heart beats. |

| Any additional evidence |
|--|
| In 2017, it was reported that a visitor died from heart failure after they were unable to access help and a defibrillator in the area. The practice told us there was a defibrillator in the village and they had improved signage at the practice entrance about where to locate help when the surgery was closed. We saw this in the front entrance. |

Continuous improvement and innovation

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

| | Y/N/Partial |
|--|-------------|
| | |

| | |
|--|-----|
| There was a strong focus on continuous learning and improvement. | Yes |
| Learning was shared effectively and used to make improvements. | Yes |
| Explanation of any answers and additional evidence: | |
| <p>In three staff files we saw staff received appraisals and had training plans in place, examples were:</p> <ul style="list-style-type: none"> Practice nurse signed up to start the non-medical prescribing course in 2019/20. <p>The practice manager verified they monitored mandatory training every month, which was confirmed by staff who showed us email prompts sent to them to complete training.</p> <p>Staff described professional networks they were linked with, where current guidance and best practice was shared and discussed for example: a practice nurse attended the locality practice nursing forum every quarter. Practice nurses specialising in diabetic care management attended a regular meeting with the secondary care diabetic nurse specialist and utilised online resources.</p> | |

Examples of continuous learning and improvement

St Keverne Health Centre is a teaching practice providing placements for fourth year medical students every year. Both GP partners were actively involved in teaching the students.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

| | Variation Band | Z-score threshold |
|---|----------------------------------|-------------------|
| 1 | Significant variation (positive) | $Z \leq -3$ |
| 2 | Variation (positive) | $-3 < Z \leq -2$ |
| 3 | No statistical variation | $-2 < Z < 2$ |
| 4 | Variation (negative) | $2 \leq Z < 3$ |
| 5 | Significant variation (negative) | $Z \geq 3$ |
| 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.
- 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.

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>

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.