

Care Quality Commission

Inspection Evidence Table

The Penryn Surgery (1-570770410)

The Penryn surgery (1-570804613)

Inspection date: 8 March 2022

Date of data download: 14 March 2022

Overall rating: add overall rating here

Safe

Rating: Good

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	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: <ul style="list-style-type: none">All GPs were trained to level 3 child and adult and safeguarding. Nursing staff were trained to level 2 and the provider aimed for all nurses to be trained to level 3 within three months of the inspection. This is in line with the Royal College of Nursing (RCN) Safeguarding Children and Young People: Roles and Competencies for Healthcare staff Intercollegiate Guidance (January 2019) and the RCN Adult Safeguarding: Roles and Competencies for Healthcare Staff (August 2018). The provider's safeguarding policies did not reflect this guidance.All staff spoken with had a good understanding of safeguarding and actions to take if they had concerns.	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> The lead GP for child safeguarding described the provider's system for identifying, flagging and sharing safeguarding information both within the practice and with other health and social care providers. There were flags to identify at risk patients, for different, specific reasons, for example, child at an address without a registered adult. The lead GP maintained a list for those patients who needed non-urgent safeguarding reviews, and these were included at the weekly meetings. The provider had weekly safeguarding reviews at their clinical meetings and also regular meetings with practice leads for safeguarding. The practice had set up a specific flag for patients with non-urgent risks relating to safeguarding, to ensure they were also reviewed at the clinical meetings. External links continued virtually during the COVID-19 pandemic. 	

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 if relevant to role.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We looked at five staff files and there was evidence that safe recruitment checks were undertaken. Staff reported a thorough recruitment and interview process. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Yes
There was a fire procedure.	Yes
Date of fire risk assessments: <ul style="list-style-type: none"> 26 July 2021 (Penryn Surgery, Saracen Way and Stithians Surgery, Crelow Lane) 	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The service completed portable appliance testing in January 2022, equipment calibration in February 2022 and fire safety certificates were in place from July 2021. There was evidence of fire drills and fire equipment checks. The provider maintained risk assessments for hazardous substances. Actions had been taken in response to external risk assessments. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out.	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes

Explanation of any answers and additional evidence:

- The practice had appointed leads for infection prevention and control (IPC) and had completed hand hygiene audits. The practice still had some cloth covered chairs and there was a programme to replace these with wipe clean chairs.
- The clinical lead attended weekly IPC meetings with the hospital lead and cascaded updates to staff.
- Staff told us the infection prevention and control systems worked well during the COVID-19 pandemic and that they had adequate personal protective equipment and guidance.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours.	Yes

Explanation of any answers and additional evidence:

- Staff reported good systems for providing staff cover. During the initial phase of the COVID-19 pandemic staff were organised into 'bubbles', to help minimise the risk of infection spreading.
- Staff worked across sites and could provide cover when necessary.
- Hot rooms were set up in Penryn Surgery, where there was direct access from the car park to control the risks of infection spread.
- At Penryn Surgery, Saracen Way, a duty doctor was available to support emergencies. There was always a doctor on site when the Penryn surgery, Stithians site was open for patient appointments.
- Stithians Surgery patients could access appointments at the Penryn surgery to promote access.
- Receptionists said they were trained to recognise unwell and/or deteriorating patients and there was a system to call the alarm for assistance in an emergency.
- Sepsis and resuscitation guidance was displayed in reception and clinical rooms.

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.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Partial
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The service had a system to manage cancer referrals with appropriate safety checks in place to ensure referrals were completed. Test results were allocated to the registered GP and were re-allocated when the GP was on leave. Abnormal results were managed by the duty doctor, following an alert raised by the test laboratory. This process was reliant on the test laboratory raising an alert to review the result. 	

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) (01/01/2021 to 31/12/2021) (NHS Business Service Authority - NHSBSA)	0.60	0.76	0.76	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). (01/01/2021 to 31/12/2021) (NHSBSA)	8.3%	9.8%	9.2%	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 (01/07/2021 to 31/12/2021) (NHSBSA)	5.08	5.32	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	109.2‰	153.7‰	129.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group	0.29	0.67	0.62	Tending towards variation (positive)

Indicator	Practice	CCG average	England average	England comparison
Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) <small>(NHSBSA)</small>				
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2021 to 30/09/2021) <small>(NHSBSA)</small>	4.3‰	6.8‰	6.7‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	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.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	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
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

Medicines management	Y/N/Partial
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Explanation of any answers and additional evidence:

- Since the last inspection, the service had improved systems for managing blank prescriptions and printer trays were locked to improve safe storage.
- There was an effective cold chain process for vaccines. Vaccines were held in a dedicated fridge in a locked room, with two thermometers and a data logger. Temperatures were checked each working day, and a log kept on when the doors had been opened for an extended time, for example for restocking.
- A new fridge had been installed at Stithians Surgery, to replace one that failed to maintain the correct temperature range.
- A robust system for monitoring medicines had been set up, with daily, weekly and monthly tasks allocated to named nurses on a rota. The daily tasks included checking the fridges, processing urine samples and checking stock levels. The resuscitation equipment was checked monthly and tagged, and expiry dates noted. This system had been implemented, with time allocated to each task, following an audit that had shown some checks had been omitted.
- Patient Group Directions were authorised and signed by staff.
- There was a lead GP for medicines management and the provider's clinical pharmacists had a key role in reviewing patient medicines and changes directed from other services.
- The provider reviewed patients on high risk medicines and medicine combinations that had been identified as high risk via the safety alert system. They had recently reviewed those who had been prescribed a combination of clopidogrel and omeprazole and those prescribed simvastatin and amlodipine. With the new clinical pharmacy lead, they planned to continue with these reviews for patients prescribed direct-acting oral anticoagulants (DOACs), used to treat or prevent blood clots.
- We found appropriate prescribing of antibiotics for children and patients with a urinary tract infection.

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
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	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, and appropriate information was supplied to patients about their medicines.	Yes
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
Explanation of any answers and other comments on dispensary services: <ul style="list-style-type: none"> A delivery service was coordinated and provided from the main surgery in Penryn, Saracen Way. 	

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:	19
Number of events that required action:	All but 2
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> All staff reported said they were encouraged to report incidents and learning was shared at meetings for wider learning. The practice maintained a log of events, showing when they occurred and were discussed and any learning or action required. The log included factors that may have contributed to the incident as well as explanations and apologies given to patients. A significant event was raised following the identification of a missed diagnosis during our remote searches and discussed at the next clinical meeting and followed up with the patient. 	

Example of significant events recorded and actions by the practice.

Event	Specific action taken
A 2-week referral was not sent. The GP had not tasked the secretary to complete the referral. The patient called	The safety net of asking patients to call back was effective however the process was changed to enable the GP to send a text to the secretary directly through the clinical record

the practice as advised if they had not heard and the referral was completed.	system, to task them to make the referral. Additional safety netting was embedded into the system.
Patient attended for a joint COVID-19 booster and Flu vaccine. Patient later informed staff she had previously received a flu jab, two weeks previously.	Additional checks were put in place to gain consent and medical history.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a process for the provider to cascade alerts, for example from the Medicines and Healthcare products Regulatory Agency (MHRA), to appropriate staff, such as prescribers. Alerts were discussed at the clinical meetings and actions monitored. • Our remote clinical records review showed safety alerts had been responded to and the provider undertook a review to check current prescribing reflected guidance from older alerts. • The provider did not maintain a log of alerts however, to help inform audit programmes that could check that prescribing continued to reflect alert guidance. • The provider undertook monthly searches of patients prescribed sodium valproate, as a result of an alert raised in September 2018 and updated in February 2021. These were set up to check for safe prescribing of the drug. This medicine, used to treat epilepsy, is associated with birth defects and the alert was issued to instruct prescribers not to give it to women able to get pregnant, unless a pregnancy prevention programme was in place. • Our remote clinical searches showed the practice had reviewed patients who were prescribed citalopram, given to treat depression, to ensure the doses were given in line with the MHRA safety alert. 	

Effective

Rating: Good

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had optimised care for their most clinically vulnerable patients during the pandemic	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice held weekly clinical meetings that included discussion of updates to evidence-based practice. Staff reported good access to training to gain specialist skills. • Nursing staff coordinated the care of patients with long term conditions and patients with a learning disability with their registered GP, to offer regular reviews, vaccinations and education. • Clinical pharmacists arranged regular medication reviews or patients with long term reviews. • Two invitations were sent to patients to encourage them to attend reviews, in line with the Quality and Outcomes Framework guidance. Thereafter, patients were invited for reviews opportunistically when they contacted the practice • There were effective systems for referring patients for acute or long term care. This included referral for early intervention by the psychosis team. As the practice has a high proportion of students, it provided weekday clinics at the university campus and had effective links with the welfare liaison team. 	

- Reviews of patient records indicated overall a good standard of care. We shared findings where checks had not been done, and in most cases the practice provided explanations for the care provided and the notes created.
- To support reviews of patients on specific care and medicine plans, the practice had recently agreed to purchase an electronic system with tools and built-in searches to monitor care, set up audits and prompt tests aligned to best practice guidance.
- During the pandemic, the practice had identified the clinically and socially vulnerable patients and ensured they were contacted to check on their needs and wellbeing.

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered annually to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check. This included an offer of cervical screening when appropriate, and a review with their GP.
- 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 identified relatives and vulnerable patients following a bereavement and offered support and signposting to local services.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The provider had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The provider had effective support systems and protocols for transgender patients, with two GP leads in this area.

Management of people with long term conditions

Findings

- We reviewed remotely the clinical records of patients prescribed Direct-Acting Oral Anti-coagulants (DOACS, or 'blood thinning' drugs used to reduce the risk of blood clots). Although we could not see that creatinine clearance was regularly monitored, the practice demonstrated they had settings within the records management system that flagged this when a prescriber re-authorised a prescription.
- We found patients prescribed medicines to lower blood pressure (Angiotensin-converting enzyme (ACE) inhibitors) were appropriately monitored.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. The practice coordinated these to offer these reviews in one appointment. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Patients over 65 years old with four or more prescription items had planned reviews including structured medicine reviews. For example the clinical pharmacist had completed specific training to support the mental health reviews.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. They used templated procedures to help ensure all the required tests and were carried out. The provider sent patients their treatment plans, such as asthma plans, after their reviews.
- Patients with asthma were offered an asthma management plan.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Records were clearly written and shared with relevant professionals involved in patients care.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England)	133	139	95.7%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England)	126	140	90.0%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England)	127	140	90.7%	Met 90% minimum

The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England)	127	140	90.7%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England)	129	146	88.4%	Below 90% minimum

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

Any additional evidence or comments

- The provider recognised that it had been difficult to encourage patients to bring their babies and young children to the surgery for their vaccines during the pandemic. The practices kept the immunisation clinics running, and there were five nurses trained to deliver baby immunisations. Overall, their immunisation rates for children aged 2 had improved in the year April 2020 to March 2021. The team had reviewed the 12-17 children who had not been vaccinated and telephoned parents to offer additional clinics at evenings and weeks. In some cases, GPs had written to parents to help explain and promote the programme. There were some families where the vaccines were declined and others where parents said their children had received vaccines abroad, however they rarely brought in evidence to enable the practice to update records accordingly.
- The practice supported the student population to receive any childhood vaccinations they had not have already received and offered targeted drop-in clinics. The practice also provided travel vaccinations.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 30/09/2021) (Public Health England)	72.9%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (PHE)	76.8%	69.5%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (PHE)	71.3%	70.1%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (PHE)	58.3%	54.9%	55.4%	No statistical variation

Any additional evidence or comments

- The provider monitored take up of cervical screening and found uptake by 25-49-year olds was lower than that of the older cohort. Uptake had also reduced during the COVID-19 pandemic. To help address this, the provider contacted patients directly to encourage them to attend. Nursing staff had allocated time to phone patients to invite them for cervical smear tests. The practice had received a letter of thanks for this approach, as it had encouraged a relative to attend who might otherwise have ignored the invitation.
- The provider had set up comprehensive annual health screening for patients with mental health needs, which included inviting them for cervical screening checks.

Monitoring care and treatment

The practice had a programme of quality improvement activity and reviewed the effectiveness and appropriateness of the care provided, however the provider had not completed a two-stage audit cycle over the previous two years.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

- The practice's focus had been on supporting the COVID-19 vaccination programme since December 2020. Additional audits had been undertaken to review
 - coil fittings during the pandemic, to assess issues and reasons for early removals
 - changes from vitamin B12 injections to oral administration
 - cancer care and learning from specific cases
 - antipsychotic drug monitoring
 - care of patients presenting with trans gender care, and the various medical pathways.
- The provider had not completed second stage audits, to show their audit programme had led to sustained improvement.
- The diabetic team had implemented a care programme for patients with diabetes, which included a support base for diet and lifestyle advice. The practice had also trained healthcare assistants with wound care.
- The practice was part of a new pilot study to assess asthma diagnosis and management. This uses the Fractional exhaled Nitric Oxide (FeNO) test to measure the level of inflammation in the lungs, when a patient exhales into a portable device.

Effective staffing

The practice was able to demonstrate that 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.	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
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff reported good support for training and development. Newly appointed GPs and nurses were allocated mentors and GPs new to practice had access to external mentors. The administration team had developed their own induction programme to promote learning and confidence for new staff. • During COVID-19, most of the required training had been completed by staff using an on-line suite of training resources. The provider had not consistently captured all the training completed outside of this system, and this was stored in different places. Each department had a process for monitoring and records staff training. • The provider supported new clinicians and supervised GP registrars, and trained medical students placed at the practice. The specialist paramedics and clinical prescribers had named GP supervision. 	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The provider contributed to the weekly PCN-wide virtual mental health multidisciplinary team (MDT) meeting • The palliative care lead attends the monthly MDT meetings to review the health and care needs of patients nearing the end of their lives. • The provider held a range of departmental meetings, including the weekly clinical meetings, reception team meetings and administration team meetings. 	

Helping patients to live healthier lives

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

	Y/N/Partial
The provider identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The provider hosts the PCN's social prescribers advertises their services on their website and via social media. The social prescribers helped people find the help and support they need to promote health and wellbeing. This included diet, smoking cessation and financial signposting. The provider supported the local park run and referred people to Nordic walking, to encourage participation in exercise. • The website contains a clear guidance on self-help and services that patients can access directly. These include services for mental health and grief, drugs and alcohol services and weight loss. wide range of support services that patients can access and a list of crisis resources for those with an acute need. • The provider has developed services to meet the welfare needs of the university students, that make up about 25% of the provider population. 	

Consent to care and treatment

The practice always obtained / was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>A review of patient records showed they were completed with good detail and included discussion relating to consent and mental capacity.</p>	

Well-led

Rating: Requires improvement

The rating has moved from Good, reported when the service was inspected in December 2018, to Requires improvement. This is because at the time of this inspection the provider did not have a registered manager in place and the partners were not all registered with the Care Quality Commission. In addition, the governance arrangements meant that provider risks were not fully identified, mitigated, managed and learning shared.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The leadership team had supported the practice and its patients throughout the COVID-19 pandemic and had implemented the national guidance effectively by guiding staff appropriately and providing clear communication campaigns for patients.• The leaders worked effectively with the primary care network (PCN) and working relationships had developed further during the COVID-19 pandemic.• Succession planning was demonstrated by the planned recruitment of new staff with handover periods and targeted training.• Staff feedback was consistently positive about the leadership team.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: The provider held monthly management committee meetings to plan and overview the direction of the locations.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behavior inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff reported on a culture that was open, supportive and caring. They said they would raise issues if they had concerns and felt their concerns would be listened to. We were also told the provider encouraged a listening culture where new ideas were invited and considered. • We were also told the culture was welcoming, friendly and caring and staff had been supported well during the COVID-19 pandemic. 	

Governance arrangements

Staff had clear roles and responsibilities to support governance and management. However, there was lack of understanding of the requirements of registration with the Care Quality Commission.

	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There were departmental team meetings and these were minuted. Where staff worked part-time on different days, the meetings were scheduled on different days of the week to promote attendance. • Time was allocated for clinicians undertaking home visits to have supervision and share information with a GP. • Minutes of meetings provided a detailed record of discussions. Minutes showed some meetings, such as the nurses meetings, did not consistently include topics such as a safeguarding, significant events, complaints and complements. • Systems for notifying CQC of changes and completing applications in respect of these changes were not fully understood and implemented. The lack of an appropriately registered manager meant governance of regulated activities was not embedded. • The provider had appointed clinical leads for different patient groups and to liaise with a range of multi-disciplinary teams, including the palliative care team. For example, there were GP leads for women's health, respiratory care, paediatrics, transgender medicine and mental health. 	

- Within the nursing team, there were leads, for example, for diabetes, respiratory care and learning disability.
- Nursing staff had allocated time to undertake regular equipment and medicine checks.

Managing risks, issues and performance

The practice did not have processes for identifying and managing risks.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	No
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:	
The provider did not have a comprehensive system for identifying, managing, mitigating and reviewing risks, such as those that might be related to, for example, training completion, feedback from external inspections and reviews, audit programmes and clinical updates. This omission may have contributed to the long-standing issues with registration. The provider had a log of complaints and incidents but did not maintain a broader risk register.	

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes

Staff were supported to work remotely where applicable.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Up to date information was available to patients on changes to access arrangements during the pandemic. This was achieved using social media and revising information on the website. The provider had purchased a new phone system which enabled them to record and manage messages to ensure they were clear, accurate and up to date. • Reception staff were trained to direct telephone calls to the most appropriate clinician for their needs. Calls were triaged and patients with most urgent needs were offered consultations on the same day. • Clinical staff continued to see patients throughout the pandemic and had set up 'hot rooms' at the start of COVID-19 for consultations with patients at risk of having the infection. • As surgeries had dispensaries on site, patients were not excluded from services and patient feedback was generally positive about access. • The provider had identified those patients who might be excluded from accessing services, and ensured they were phoned or received letters as appropriate to their needs. • The learning disability nurse phoned patients for their checks and they were seen face to face when this was appropriate. • Home visits continued during the pandemic, based on individual patient need. • Clinical staff could work remotely when they needed to self-isolate. • The practice reviewed and acted upon the infection control advice issued in relation to COVID-19. • Online consultation was available but not used widely. Patients were supported to send photos to the GP when this helped with their diagnosis and treatment. 	

Appropriate and accurate information

The practice did not always act on appropriately on changes and information.

	Y/N/Partial
Staff used data to monitor and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	No
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The person listed as the registered manager had left The Penryn Surgery in 2016 but had not applied to the Care Quality Commission (CQC) to cancel their registration. This had been highlighted by the provider to CQC and the report from the last CQC inspection in 2018 stated CQC had agreed to initiate a process to cancel the registration to enable a new manager to apply. The provider acted promptly when advised of the situation to guide the incorrectly registered manager to submit their application to cancel their registration. • The GP intending to be the registered manager had initiated the process by completing their DBS application. • The partners listed in the provider's registration did not match the provider's actual partnership. There were only two GP partners registered by the provider at the time of the inspection. The providers partners submitted applications to join the partnership when this was highlighted. 	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Explanation of any answers and additional evidence: Information was provided on the provider's website and the provider had created an online services brochure for patients to reference.	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Partial
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The provider received patient feedback via social media and NHS choices. The last four comments on NHS choices were positive, and patients gave top ratings. Comments included 'wonderful practice', 'topflight care', 'couldn't fault them' and 'seen by doctor without delay'. The provider responded to people who made comments on social media, thanking them for their feedback and offering advice specific to their comments. Changes were made in response to patient feedback. For example, one patient suggested they change the music when they were put on hold. The provider made changes accordingly. The provider had a system for monitoring and responding to complaints. This was an area suggested for improvement in the previous inspection. 	

- Staff had been invited to participate in a survey in winter 2021. The provider had started to implement changes as a result, such as having GP representation at reception team meetings and improving communication processes.
- The provider worked well with partners in the Primary Care Network (PCN), particularly during the COVID-19 pandemic to coordinate vaccination programmes.
- The PCN had recently agreed to relaunch the Patient Participation Group (PPG) to cover all the practices, following a reduction in engagement during the COVID-19 pandemic. Membership was promoted via social media and the website, and the practice had contacted over 100 patients who had expressed an interest to invite them to the PCN virtual PPG meeting.
- The last patient survey, with results from January 2021 to March 2021, showed patients rated the provider better than others in England, and the CCG, for being treated with care and compassion, for having confidence in their healthcare professional and for their overall experience of the practice. They also were more positive about appointment times.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The provider had agreed to purchase a clinical management system with clinical pathways and audit proformas, to help clinicians keep up to date. • The safeguarding lead reviewed those who might be vulnerable but did not meet the thresholds, to ensure any potential risks were • The provider implemented safety improvements in response to significant events. • The provider participated in a pilot study to identify and improve the outcomes for patients with asthma. 	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

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