

Care Quality Commission

Inspection Evidence Table

Penntorr Health (1-2017759954)

Inspection date: 25 August 2021

Date of data download: 18 August 2021

Overall rating: Good

At our inspection in November 2019, we rated the practice as Requires Improvement overall as the practice had not established effective systems and processes to ensure good governance in accordance with the fundamental standards of care. The provider has since made improvements in respect of these arrangements and we have now rated the practice as Good overall.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe

Rating: Good

At our inspection in November 2019, we rated Safe as requires improvement as the arrangements in respect of infection prevention and control needed improving. During this inspection we saw that arrangements for delivering safe care and treatment had significantly improved and have now rated the practice as 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 which were accessible to all staff. | Yes |
| Policies and procedures were monitored, reviewed and updated. | Yes |
| Partners and staff were trained to appropriate levels for their role. | Yes |
| 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 |

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

| 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 |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | Yes |

| Safety systems and records | Y/N/Partial |
|--|--------------------|
| There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: Penntorr Health November 2020 Millbrook November 2020 | Yes |
| There was a record of equipment calibration. Date of last calibration: | 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 |
| A fire risk assessment had been completed. Date of completion: Penntorr Health August 2021 Millbrook August 2021 | Yes |
| Actions from fire risk assessment were identified and completed. | Yes |

| Health and safety | Y/N/Partial |
|--|--------------------|
| Premises/security risk assessment had been carried out. Date of last assessment: August 2021 | Yes |
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: August 2021 | Yes |

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

| | Y/N/Partial |
|---|-------------|
| There was an infection risk assessment and policy. | Yes |
| Staff had received effective training on infection prevention and control. | Yes |
| Infection prevention and control audits were carried out. Date of last infection prevention and control audit: August 2021 | Yes |
| The practice had acted on any issues identified in infection prevention and control audits. | Yes |
| There was a system to notify Public Health England of suspected notifiable diseases. | Yes |
| The arrangements for managing waste and clinical specimens kept people safe. | Yes |
| Explanation of any answers and additional evidence: At our inspection in November 2019, we found an infection prevention and control audit undertaken at Millbrook Surgery in May 2019 had not identified that the internal cleaning company had not kept records to confirm general cleaning had been completed. At this inspection in August 2021, we saw records to demonstrate cleaning had been undertaken. | |

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 |

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 |
| 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 |

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) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA) | 0.87 | 0.71 | 0.70 | 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). (01/04/2020 to 31/03/2021) (NHSBSA) | 11.1% | 11.2% | 10.2% | 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 (01/10/2020 to 31/03/2021) (NHSBSA) | 6.55 | 5.44 | 5.37 | Tending towards variation (negative) |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA) | 170.9‰ | 150.1‰ | 126.9‰ | No statistical variation |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA) | 0.68 | 0.72 | 0.66 | No statistical variation |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA) | 5.4‰ | 6.5‰ | 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 |

| Medicines management | Y/N/Partial |
|--|-------------|
| The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review. | 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 |
| <p>Explanation of any answers and additional evidence:</p> <p>At our inspection in November 2019, we noted that not all Patient Group Directions (PGDs) had been signed by all staff from the date the PGD was valid from. However, at the time of inspection, PGDs used to administer medicines had been signed by all appropriate staff. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment).</p> <p>At this inspection in August 2021 we reviewed the PGD's and saw that all were signed and dated appropriately.</p> <p>The practice sent us evidence to demonstrate the prescribing competence of non-medical prescribers. Reviews of their prescribing practice was completed by a GP and took place six monthly.</p> | |

| Medicines management | Y/N/Partial |
|--|-------------|
| <p>As part of our remote inspection we reviewed patient records to ascertain the appropriate monitoring and clinical review was being undertaken prior to providing patients with repeat prescriptions. We found that all monitoring and reviews were being carried out appropriately.</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 |
| Explanation of any answers and additional evidence: Significant events could be identified by any member of the practice team. They were all examined at the management, clinical and reception team meetings and consideration was given to what actions could be taken to prevent a similar situation occurring again. | |

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

| Event | Specific action taken |
|---|--|
| An econsult from a patient requesting medicine was uploaded onto another patients file who had the same first name and similar date of birth. The error was highlighted when the patient called the practice to advise that she had not requested medicine. | The error was discussed at the next significant event meeting and the administrative staff were to ensure that they checked three types of patient information, name, date of birth and address before they uploaded the documentation onto patients' files. |

| 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 |

Effective

Rating: Good

At our November 2019 inspection we rated the practice as Requires Improvement for this key question because there was limited monitoring of the outcomes of care and treatment. We have now seen improvements in many of these areas and have rated the practice as Good for providing effective services.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment were 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 |

Older people

Population group rating: Good

| Findings |
|---|
| <ul style="list-style-type: none">• The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.• The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.• The practice carried out structured annual medicines reviews for older patients.• Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.• Health checks, including frailty assessments, were offered to patients over 75 years of age.• Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group. |

People with long-term conditions

Population group rating: **Good**

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

| 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. (01/04/2019 to 31/03/2020) (QOF) | 76.7% | 73.1% | 76.6% | No statistical variation |
| PCA* rate (number of PCAs). | 3.8% (29) | 13.6% | 12.3% | 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 (01/04/2019 to 31/03/2020) (QOF) | 94.8% | 86.9% | 89.4% | No statistical variation |
| PCA rate (number of PCAs). | 13.6% (33) | 16.1% | 12.7% | N/A |

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

| Long-term conditions | Practice | CCG average | England average | England comparison |
|----------------------|----------|-------------|-----------------|--------------------|
|----------------------|----------|-------------|-----------------|--------------------|

| | | | | |
|--|-------------|-------|-------|--------------------------|
| The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small> | 85.4% | 80.7% | 82.0% | No statistical variation |
| PCA* rate (number of PCAs). | 11.5% (40) | 7.0% | 5.2% | N/A |
| The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small> | 76.3% | 70.6% | 66.9% | No statistical variation |
| PCA rate (number of PCAs). | 28.3% (180) | 23.5% | 15.3% | N/A |
| The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small> | 76.3% | 72.7% | 72.4% | No statistical variation |
| PCA rate (number of PCAs). | 13.7% (193) | 10.4% | 7.1% | 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 (01/04/2019 to 31/03/2020) <small>(QOF)</small> | 87.0% | 89.9% | 91.8% | No statistical variation |
| PCA rate (number of PCAs). | 7.4% (19) | 5.1% | 4.9% | N/A |
| The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small> | 83.1% | 78.5% | 75.9% | No statistical variation |
| PCA rate (number of PCAs). | 17.3% (110) | 13.5% | 10.4% | N/A |

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Findings

- The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for the five childhood immunisation uptake indicators. The practice was just below the minimum 90% target for all four childhood immunisation uptake indicators. They promoted uptake of immunisations and provided opportunistic vaccinations when appropriate.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

| Child Immunisation | Numerator | Denominator | Practice % | Comparison to WHO target of 95% |
|--|-----------|-------------|------------|---------------------------------|
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England) | 86 | 98 | 87.8% | Below 90% minimum |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England) | 73 | 85 | 85.9% | Below 90% minimum |
| The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England) | 73 | 85 | 85.9% | Below 90% minimum |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England) | 76 | 85 | 89.4% | Below 90% minimum |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England) | 106 | 120 | 88.3% | 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 practice were aware of their lower figures. The practice told us they were ensuring that three reminder letters were sent out to non-attenders and also the practice nurse telephoned to discuss with parents any concerns they may have. We were told that many parents preferred to have their child's immunisations separately over three visits and these affected the figures.

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 medicines 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). (Snapshot date: 31/03/2021) (Public Health England) | 73.2% | N/A | 80% Target | Below 80% target |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE) | 70.1% | 74.8% | 70.1% | N/A |
| Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE) | 68.4% | 66.8% | 63.8% | 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 (01/04/2019 to 31/03/2020) (QoF) | 92.3% | 92.3% | 92.7% | N/A |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE) | 64.0% | 53.5% | 54.2% | No statistical variation |

Any additional evidence or comments

The practice were aware of being below the 80% target. The provider told us they continue to try to encourage women to attend for cervical screening.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

**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.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medicines.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

| 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 (01/04/2019 to 31/03/2020) <small>(QOF)</small> | 96.3% | 88.6% | 85.4% | No statistical variation |
| PCA* rate (number of PCAs). | 30.8% (24) | 21.6% | 16.6% | 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 (01/04/2019 to 31/03/2020) <small>(QOF)</small> | 97.8% | 83.1% | 81.4% | Variation (positive) |
| PCA rate (number of PCAs). | 10.1% (10) | 8.9% | 8.0% | N/A |

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

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 | England average |
|--|----------|-----------------|
| Overall QOF score (out of maximum 559) | 556.4 | 533.9 |
| Overall QOF score (as a percentage of maximum) | 99.5% | 95.5% |
| Overall QOF PCA reporting (all domains) | 9.1% | 5.9% |

| | 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. | Yes |
| The practice regularly reviewed unplanned admissions and readmissions and took appropriate action. | Yes |

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

An audit was undertaken using computer software to ensure Warfarin, a blood thinning medicine, was being monitored effectively. Taking this medicine requires regular blood tests called the international normalised ratio (INR) to check how long it takes for the blood to clot. Most patients taking this medicine have a ratio of between 2 and 3.5 They particularly looked at results were particularly high or low. The percentage of patients developing an INR above 5.0 had significantly fallen by 10.2% on the previous year from 18.6% to 8.4%. The percentage of INR readings below target was 5.21%.

The audit also looked at the diagnostic coding for why a patient is on warfarin and patients who were overdue for testing or have completed their treatment duration so that warfarin may be stopped. The percentage of patients with an unknown diagnosis remained at 0.00% for both years and there had been no major bleeds or patients with unknown stop dates.

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. | 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 |

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-centered care when they moved between services. | Yes |

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 |
| 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 |
| The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity. | Yes |
| Explanation of any answers and additional evidence: The practice also used a website that improved signposting for people to the correct service, improved uptake of online services, improved the identification of carers and make it easier for people to communicate with the practice in different ways, for example, video consultations. | |

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 |
| Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. | Yes |

Well-led

Rating: Good

At our inspection in November 2019 the practice was rated as requires improvement for providing Well-led services. This was due to shortfalls regarding the effectiveness of governance systems and the management of risks and performance.

At this inspection the practice had developed processes and systems for the governance to manage risk and performance. We have now rated the practice as Good for providing well-led services.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels. Leaders could demonstrate that they had the capacity and skills 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 |
| Explanation of any answers and additional evidence: The practice was working with other practices in the area as a Primary Care Network. Engagement with other practices within the federation was effective and all communications were discussed to improve the services and plan for future development of the practice. We saw that leaders effectively communicated with staff through team meetings, practice meetings, notifications, and emails. Staff told us they had been consulted regarding changes made to services provided. | |

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 them. | Yes |

| | |
|--|-----|
| Progress against delivery of the strategy was monitored. | Yes |
|--|-----|

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 |
| 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's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy. | Yes |
| The practice had access to a Freedom to Speak Up Guardian. | Yes |
| Staff had undertaken equality and diversity training. | Yes |

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

| Source | Feedback |
|---------------------|---|
| Staff Questionnaire | Staff told us that there are very professional relationships between individuals and teams, within an open culture. They told us they have clear roles and responsibilities and feel supported by managers and leaders. |

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 |

Managing risks, issues and performance

There were 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 quality improvement programme in place. | 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 |

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 |
| Explanation of any answers and additional evidence: The practice had introduced a new telephony system that allowed them to monitor the number of calls being received into the practice and adjust staffing as required. | |

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

| | Y/N/Partial |
|--|-------------|
| Staff used data to monitor and improve performance. | Yes |
| Performance information was used to hold staff and management to account. | 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 purchased a new computer software programme which supported safety compliance, through holding training records, HR checks, safety alert information and actions, complaint recording and significant event analysis. The tool was very visual, allowing for the manager to see, for example, whose training was up to date, and what refresher training was due. It also emailed both the employee and manager to remind them that action was required. | |

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 |
| The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services. | Yes |
| Online consultations took place in appropriate environments to ensure confidentiality. | Yes |
| The practice advised patients on how to protect their online information. | Yes |

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. | 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 |
| Explanation of any answers and additional evidence: | |
| The practice maintained good links with the local community through the Patient Participation Group and CHAT (Community Health around Torpoint). The Group had been re-launched in 2020 as a virtual group with wider membership and a better cross-section of representation of the community. | |
| The practice manager and nominated GP partner engaged with the virtual PPG through ad-hoc surveys, queries, a weekly email update from the practice manager, together with ad hoc updates for any developments as they arise. | |
| During the Covid pandemic the practice also formed positive a relationship with the Local Council. They provided the Council Chambers as premises for pop up vaccination clinics together with a number of volunteers for the clinics. | |

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: | |
| The practice is committed to undertake clinical trials in which patients help test treatments or approaches to prevent or diagnose health conditions to evaluate whether they are safe and effective. | |
| The practice demonstrated innovation and sought opportunities to expand the range of services provided locally, as demonstrated by hosting the dermatology service. They told us the 2020 Covid-19 pandemic had provided opportunities for change and openness to new ways of working. For example, video consultations and closer working within the primary care network. | |

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.
- *PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
-
- ‰ = per thousand.