The Stennack Surgery

Inspection report

The Old Stennack School
Stennack
St Ives
Cornwall
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

Overall summary

This practice is rated as Outstanding overall. (Previous inspection October 2015 – Outstanding)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? - Outstanding

We carried out an announced comprehensive inspection at The Stennack Surgery on

10 October 2018. The inspection was a routine inspection part of our inspection schedule.

At this inspection we found:

- Despite some significant challenges in the last few years the leadership had demonstrated resilience and commitment to their patients and the wider community. They had continued to implement the strategy with the delivery of objectives that were stretching, challenging and innovative.
- The practice had a clear vision which had quality and safety as its top priority. A five year strategy was in place, monitored and regularly reviewed and discussed with all staff and patient representatives.
- Feedback from all 30 patients we spoke with or who provided feedback, who used the service, family members and carers, and stakeholders were continuously positive about the way staff treated them. Staff were said to go the extra mile and were patient focussed in all aspects of care delivery and developments at the practice.
- People's individual needs and preferences were central to the planning and delivery of flexible tailored services.
- Integrated health and social care was strongly advocated and the practice had driven innovation in the integration of community services in the Penwith locality.
- All patient feedback highlighted improved ease of access to the appointment system after a short period of resource challenges.
- The practice was proactive in addressing lower uptake rates of childhood immunisation, providing flexible clinics and appointments, immunisation champions to engage and educate parents in hard to reach families.
- Patient engagement was a high priority with patient representatives seen as critical partners actively involved in developing services.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. Proactive succession planning was evidenced.
- Leaders had an inspiring shared purpose, strove to deliver and motivated staff to succeed.
- GP partners invested heavily in the practice, purchasing the building. The risk and business management was effective with data showing significant benefits for patients and NHS health budget savings made as a result.

We saw areas of outstanding practice:

There was a strong communitarian approach, with many examples seen demonstrating this: Patients had immediate and easy access to the many types of support available from representatives at the practice community hub including information, exercise and social activities to prevent social isolation and loneliness and improve health.

The practice identified patients living in St Ives all year round to determine who the community is, who needed help, and who the practice needed to connect with to provide support. This facilitated proactive identification of people who could be at or likely to become frail and at risk.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Population group ratings

Older people	**Outstanding** ☆
People with long-term conditions	**Outstanding** ☆
Families, children and young people	**Outstanding** ☆
Working age people (including those recently retired and students)	**Outstanding** ☆
People whose circumstances may make them vulnerable	**Outstanding** ☆
People experiencing poor mental health (including people with dementia)	**Outstanding** ☆

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser and a practice nurse adviser.

Background to The Stennack Surgery

The partnership of GPs registered as the Stennack Surgery runs one registered location, which was inspected on 10 October 2018. This was a comprehensive inspection. The practice is located at:

The Old Stennack SchoolStennackSt IvesCornwallTR26 1RU

The practice provides a primary medical service to approximately 12,200 patients of a diverse age group. The practice population is in the sixth deprivation decile for deprivation. In a score of one to ten the lower the decile the more deprived an area is. Some surrounding villages have higher levels of deprivation. There is a practice age distribution of male and female patient's equivalent to national average figures. Average life expectancy for the area is similar to national figures with males living to an average age of 81 years and females to 85 years.

The Stennack Surgery is a semi-rural general practice in St Ives, a popular retirement destination resulting in a higher than average patient population aged over 65. This increases during the summer months due to tourism in the area. On average 2000 temporary residents attend the practice annually due to tourism, but since April 2018 the practice had seen a 50% rise.

The partnership at the practice comprises of four GPs partners supported by six salaried GPs (five male and five female). The team are supported by a practice manager and a management team, seven practice nurses three are nurse practitioners, a paramedic, three healthcare assistants and a clinical pharmacist. There is a team of administrative and reception staff.

The Stennack Surgery is an approved training practice providing vocational placements for GPs registrars. Two GP partners are approved to provide all three years of training for GPs. On GP partner is an academic tutor for the Deanery and a trainer for second year post qualification doctors. There is a practice nurse mentor and teaching placements were provided for medical students and student nurses. A GP ST1 registrar, F2 Doctor and Medical Student Year 3 were on placement when we inspected.

Patients using the practice also have access to a midwife, community nurses, mental health teams and health visitors. Other health care professionals visit the practice on a regular basis.

Stennack Surgery is open from 8 am – 8 pm Monday to Friday. The practice has a same day team, comprising of GPs and nurse practitioners with urgent appointments available on the day for patients. Appointments are available in the evening and telephone consultations

offered for working patients. Routine appointments can be booked up to 6 weeks in advance. Appointments are usually for 10 minutes but longer appointments are available on request.

There is a minor injury unit at the practice open between 8am – 8pm Monday to Friday (including some Bank holidays except Christmas Day and Boxing Day). This is a walk-in service, where no appointment is needed. This service is able to treat patients with minor injuries, such as lacerations, sports injuries and infections. All other patients experiencing major trauma, head injuries, poisonings or major collapse are directed to the main hospital in Truro.

Young person (under 25 yrs) focussed services are available at the practice:

- Young person's drop-in clinic for all patients under 25 years old is held every Wednesday, from 4pm – 6pm.
- Brook sexual health drop in clinic every Monday 3.30-6pm
- C-CARD - a confidential, free condom distribution scheme for young people living in Cornwall and Isles of Scilly is available. The scheme aims to make condoms more accessible and gives young people support and information about sexual health and how to use a condom correctly.

Outreach flu clinics were being held in Carbis Bay throughout the autumn and winter months. Information about these clinics is available on the practice website and in the waiting room.

Outside of these times patients are directed to contact the out of hour's service by using the NHS 111 number.

The practice is registered to provide the following regulated activities: Diagnostic and screening, Surgical procedures, Family planning services, Maternity and midwifery services and Treatment of disease, disorder or injury

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

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

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- We reviewed four files, two of which were for locum GPs and found the practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

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

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. The practice had a period of instability over the last 12 months due to staff retirements. Staffing resources were reviewed and changes made to skill mix and cover for absence. GPs had a buddy who covered them if they were absent or on leave. The new protocol stated no more than a maximum of two GPs could be off on the same day and buddies were discouraged from taking the same days off. All annual leave was now discussed at the senior management team and signed off by GP partners.
- There was an effective induction system for temporary staff tailored to their role. This included an induction pack should any locum staff work at the practice. Three retired GP partners did the majority of locum cover with a salaried locum GP providing maternity cover for continuity of care.
- The practice was equipped to deal with medical emergencies and staff were trained to a high level in emergency procedures. The advanced nurse practitioner provided BLS (British life-saving) training for staff as she was an experienced advanced life support trainer. The practice had its own their own resuscitation model, purchased through fundraising, enabling staff to practice cardiopulmonary respiration with a defibrillator during training sessions.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. Assessment tools were seen displayed in all clinical areas for the assessment of deteriorating patients, including those at risk of developing sepsis. Information was displayed in the waiting room for patients about early symptoms of sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

- The practice used a risk management system, which enabled patient records to be analysed to produce risk profiles to target audit activity, health screening and ongoing monitoring of patients. The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There was a documented approach to managing test results.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

Good

Are services safe?

The practice had reliable and improved systems for appropriate and safe handling of medicines.

- Stennack Surgery had made improvements for assurance of quality and effectiveness of prescribing and reviewing patient needs. A prescriptions team was set up by the practice with specialist staff, including a practice based pharmacist and pharmacy technician. The pharmacist met with patients reviewing their medicines with them, carried out audits and searches on receipt of any medicines alerts or optimisation team requests and took action where necessary.
- The systems for managing and storing medicines, including vaccines and those transported to Carbis bay for outreach flu clinics, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to all safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture of safety that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice and the wider health and social care community in Penwith.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts. An audit was undertaken on receipt of the safety alert in 2017 about the risks of sodium valproate (a medicine for epilepsy). This demonstrated the practice had identified all childbearing female patients who were prescribed sodium valproate, reviewed and altered the prescription where appropriate and advised them of the associated risks during pregnancy. Any patients continuing to be prescribed sodium valproate continued to be monitored and changes made where ever possible. A recent alert about a device delivering emergency medicine used to treat patients who experiencing early anaphylactic shock (an emergency situation) was audited by practice pharmacist and actions taken to recall patients affected.

Please refer to the Evidence Tables for further information.

Good

Are services effective?

We rated the practice and all of the population groups as good for providing effective services .

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice had near patient diagnostic equipment, including: blood testing for any patients on anti-clotting medicines (warfarin) enabling patients to receive the result and guidance about dosing before leaving the practice. A dermatoscope to examine skin lesions so any concerning findings for patients were escalated to the dermatologist.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had regular clinical reviews including a review of medication. The practice had a weekly meeting to discuss all patients on the frailty register with the multidisciplinary team.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP and clinical pharmacist worked with other health and care professionals to deliver a coordinated package of support and care.
- Practice nurses were responsible for reviews of patients with long term conditions and had received specific training. There were several nurse practitioners with diploma qualifications covering minor injuries, the management of patients with diabetes and respiratory conditions such as asthma and chronic pulmonary disease.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. Standardised templates were used to assess patients to identify any risks, which prompted specific follow up actions.
- The practice's performance on quality indicators for long term conditions was in line with local and national averages.

Families, children and young people:

- Childhood immunisation uptake rates were at or below the target percentage of 90%. Data showed in 2016/17 four immunisation indicators were below this target ranging from 89% for children under one and 83% for children over two years old. The practice shared data with us for 2017/18, which demonstrated improvement. For example, the percentage of children aged 2 who had received one dose of MMR had increased 3.5% on the previous year to 86.5%. The percentage of children aged 5 who had a complete course of MMR for 2017/18 had increased 13.2% to 96.2%. The practice successfully bid for funding for a childhood immunization quality improvement project, with an extended hours flexible

appointment system (evenings and weekends) and immunisation champion engaging with hard to reach families to increase uptake was underway when we inspected.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening (CVS) was 71%, which was just below the 80% coverage target for the national screening programme. The practice uptake was in line with the local (75%) and national (72%) averages. Staff verified every contact with eligible women was used to encourage and support them to have cervical screening.
- The practice was aware that 29% of women were not attending for CVS and in the process of investigating if there were any patterns for this so they could target the patients they needed to. This included working closely with the local secondary school to raise awareness with young women about the CVS programme in their adult lives.
- The practice's uptake for breast and bowel cancer screening was in line with the national average.
- 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 40-74 at least every five years were being introduced from January 2019. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- Staff received training and support to facilitate early identification of victims of abuse and signposting to specific support services.

People experiencing poor mental health (including people with dementia):

- The practice jointly assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder with the community mental health team every month. Patients were able to access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for review of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. All patient or carer contacts from patients in crisis were treated as urgent and referred immediately to the GP. The practice had initiated a wider investigation of unplanned deaths in the locality. There was no learning for the practice, however GPs had requested further training to assess patients in mental health crisis.
- 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.
- The practice offered annual health checks to patients with a learning disability.
- The practices performance on quality indicators for mental health was in line with local and national averages. Data from 2016/17 showed a slightly higher exception rates for reviewing patients with mental illness. However, unpublished data for 2017/18 showed the practice had reduced this and significantly increased review performance to 99%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate). The majority of patients falling into this group were under the care of the mental health team, which accounted for the figures.
- The practice had utilised staffing resources and skills increasing the level of reviews carried out for patients living in care homes. In 2015, we found the practice had created a substantive nursing post specifically for

monitoring patients with frailty, complex and/or living at home and in care homes. The service had been reviewed following the retirement of staff and extended since the last inspection.

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. Where appropriate, clinicians took part in local and national improvement initiatives.

- Data for 2016/17 demonstrated the practice was achieving comparable results compared with local and national practices. At the time of the inspection, the practice shared the unpublished data for 2017/18 which demonstrated the practice was on a trajectory of improvement and still comparable with local and national practices However, other benchmarking data showed the practice admission rate for asthma was in lowest percentile for Kernow Clinical Commissioning Group. The practice had one of the highest rates of carrying out reversibility for asthma which meant patients were having more in-depth tests to determine the most effective treatment to manage their condition and reduce the risk of asthma attacks where possible. Locality benchmark data demonstrated overall patient hospital admissions for acute cardiac symptoms (heart attack), exacerbations of acute chronic pulmonary disease or diabetic crisis were low when compared across the locality.
- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date. The practice management team had oversight of all mandatory and specific training via an online system and were able to demonstrate staff had updated or were due to later in the year.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable. The practice had a competency framework, which staff were familiar with setting out values and behaviours expected of them.
- The advanced nurse practitioner provided ILS (intermediate life-saving) training for staff as she was an experienced advanced life support trainer. The practice had equipment purchased through fundraising to provide staff to practice cardiopulmonary respiration with a defibrillator during training sessions. This experience translated into successfully resuscitating a patient who had a cardiac arrest.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when

they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

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

- Since 2015, the practice had set up a community hub run in the waiting room providing patients with information and access to healthy living support, sport and advice. Through this hub staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- The practice identified patients who may be in need of extra support and directed them to relevant services such as the community matron, hospice and palliative care teams. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity. Locally based campaigns such as 'Headstart' a mental health resilience campaign for young people and children in Cornwall was promoted by the practice.
- The practice continued to engage well with young people at the secondary school, raising awareness about the cervical screening programme with young female patients in readiness for their adult lives aimed at increasing uptake.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately and had reviewed this following the introduction of the General Data Protection Regulations earlier this year.

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from 30 patients was strongly positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's GP patient survey results were in line or above local and national averages for questions relating to kindness, respect and compassion.
- Stennack Surgery had a communitarian approach, linking with all aspects of the community. Staff had supported a local teenage mental health charity – Invictus Trust by running a coastal path relay race. A local charity had been identified, which the practice was fundraising for up to Christmas.
- The practice had a long-established charity, the 'Friends of Stennack Surgery', which had raised considerable funds. One of the highlights for the community of St Ives and surrounding areas each year was the Christmas concert held at the practice. We were told this provided comfort and cheer particularly for people who could otherwise be socially isolated. At this event, the permanent shop sold items donated by patients and carers.

Involvement in decisions about care and treatment

Staff helped patients to be actively involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available such as a hearing loop, signage in line with RNIB recommendations.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.
- The practices GP patient survey results were in line local and national averages for questions relating to involvement in decisions about care and treatment. After a difficult period when there had been staffing resource challenges, improvements were seen in patient perceptions of the services. The percentage of respondents to the GP patient survey who answered positively about whether they had confidence in their GP was in line with local and national averages.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the evidence tables for further information.

Outstanding ☆

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as outstanding for providing responsive services

Services had been developed further to reach the entire population, since the last inspection in 2015. Stennack Surgery is rated outstanding for responsive because:

- People's individual needs and preferences continued to be central to the planning and delivery of flexible tailored services with a social prescribing focus.
- The involvement of other organisations and the local community continued to be integral to how services were planned to meet patient needs. There were innovative approaches to providing integrated person-centred pathways of care that involve other service providers, particularly for people with multiple and complex needs. The practice had a 'Connected Communities' group formed to target social isolation with weekly activities and a pop up café on a monthly basis.
- There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that meets these needs and promotes equality. This was particularly so for people who were it risk of or in vulnerable circumstances or who had complex needs. The practice set up a community hub model, which was recognized as an exemplar for other practices in Kernow.
- People were able to access appointments and services in a way and at a time that suited them.
- There was active review of complaints and how they were managed and responded to, and improvements are made as a result. People who used services were involved in the review.

Responding to and meeting people's needs

Services were tailored to meet the needs of individual patients and were delivered in a way to ensure flexibility, choice and continuity of care.

- The practice clearly understood the needs of its population and tailored services in response to those needs. There was evidence of practice driving a number of locality based projects and services to ensure patients' needs were met in the Penwith area.
- The practice patient list remained fairly static between 2015 and 2018. However, the number of available appointments being delivered in October 2018 was between 1209 and 1483 compared with 952 seen per week in 2015. The practice was delivering more than a third more appointments since we last inspected in 2015.
- The number of temporary patients visiting the practice during peak holiday periods had risen by 50% in 2018. The practice had responded by increased staffing during these periods and over some bank holidays opening the minor injuries unit between 10am to 4pm every Saturday as well as 8am to 8pm every weekday.
- The GP partnership had secured additional resources via internal investment and external funding to meet patients varied and complex needs, including a social prescriber, a clinical pharmacist, medicines technician, nurse practitioner/prescriber and two primary care professionals.
- The practice provided a wide range of appointment types, including a daily walk in service at the minor injuries unit, to improve choice and accessibility for patients.
- GPs had appropriate skills and qualifications to give joint injections and carry out minor surgical procedures for patients.
- Urgent and pre-bookable telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered. The practice purchased the premises in 2017 demonstrating long-term commitment to the strategic plans to develop services for the community of St Ives and locality of Penwith.
- The 'Friends of Stennack Surgery' continued to enable the practice to be well equipped. Near patient testing equipment facilitated onsite assessment and diagnosis for patients who otherwise might struggle to attend the local acute hospital for assessment and diagnosis due to deprivation and limited transport links. Equipment purchased in the last 12 months included: D Dimer machine (equipment for testing patients with a risk or pulmonary embolus or deep vein thrombosis), Dermatoscope (for examination of skin lesions for early diagnosis) and a centrifuge to give more flexibility on sending samples to the laboratory so patients were able to have later appointments for blood taking

Outstanding ☆

Are services responsive to people's needs?

- The practice made reasonable adjustments when patients found it hard to access services. The premises were fully accessible to those with restricted mobility and the practice had accessible parking spaces and wheelchairs for patients to use if necessary.
- For patients with visual impairments, signage followed RNIB guidelines.
- The practice provided effective care coordination for patients who were more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services such as the palliative care and hospice teams.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. Since the last inspection in 2015, the practice had reviewed its home visiting service to vulnerable patients originally run by a practice nurse who had since retired. The majority of these visits to housebound patients living in their own homes or one of three care homes were now carried out by two primary care practitioners. The two clinicians worked opposite shifts providing cover across the day to do planned and responsive visit to patients. Routine weekly visits were carried out to three care homes to see patients and support staff carers.
- A medicines technician was appointed and acted as the care home liaison for prescriptions, supported by the practice pharmacist.
- The practice recognised its patient population group had more than twice the number of patients aged 65 and above. Decisions to retain paper and telephone systems benefitted frail and elderly patients. Example seen included, patients being able to request repeat prescriptions over the telephone. This had been phased out in other areas of the country.
- Through the community hub set up by the practice, up to thirty carers were regularly attending a lunch club, which helped to reduce the risk of social isolation for them.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held weekly meetings with the local community nursing teams to discuss and manage the needs of patients with complex medical issues.
- Double appointments were offered for specific services such as insulin initiation.
- The practice directly employed a clinical pharmacist and medicines technician, whose role included audit and recall of patients with long term conditions. Patients were able to book face to face reviews with the clinical pharmacist.
- The National Diabetes Prevention Programme was underway at the practice. Patients with an HbA1Cs between 42-47 (borderline blood sugar suggesting the patient could be pre-diabetic) were identified and referred for targeted lifestyle advice. A weekly Diabetes Support Group run by Diabetes UK was held in the practice community hub.

Families, children and young people:

- The practice had a young person's clinic (under 25s), which ran every Wednesday between 4pm and 6pm. No appointment was required. Since the last inspection, arrangements were put in place to host the Brook sexual health drop in clinic at the practice every Monday 3.30pm to 6pm for Under 25's
- Patients were able to access the C-CARD scheme - a confidential, free condom distribution scheme for young people living in Cornwall and Isles of Scilly. The scheme aims to make condoms more accessible and gives young people support and information about sexual health and how to use a condom correctly.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day

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appointment when necessary. The practice offered flexible specific children's appointment slots in the morning, afternoon, late evenings and weekends to increase immunisation uptake for hard to reach families.
- The practice offered dual GP and practice nurse six to eight-week checks for both mothers and babies for convenience.
- Long-acting reversible contraception services (LARC) were offered at the practice for female patients.
- GP and nurse cancer leads had received training from Macmillan facilitators to improve newly diagnosed cancer patient care. Every patient had a holistic patient-centered assessment. New links with Cornwall Hospice Care had resulted arrangements for drop-in support services from the practice community hub to raise awareness of end of life care and provide access to complementary therapies.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, appointments were offered from 8am to 8pm on weekdays which suited those of working age. Patients could choose from GP, nurse and minor illness appointments, either pre-bookable or book on-the-day after 6.30pm.
- Telephone appointments were available each day with GPs and the practice pharmacist.
- Immediately after the inspection, the practice was due to go live with e-consult (receive online advice for routine health matters) to further improve access for working age patients. Patients were able to access their records, book appointments and order prescriptions online or by a dedicated phone line.
- There was a 24/7 automated telephone service for patients to request repeat prescription.
- Patients were able to access travel advice and vaccines. The practice offered both NHS and non NHS travel vaccines, including yellow fever, and immunisation updates.
- The practice actively promoted online services, used social media and the patient participation group to promote practice events and community services.
- Patients could access health promotion appointments for assessment and advice. Healthcare assistants had extended training and assessed as competent to provide appointments for a range of issues.
From January 2019 the practice was due to provide NHS Health checks and were able to use a blood pressure monitor that can detect an irregular pulse to aid atrial fibrillation (heart disease) detection for early treatment.

People whose circumstances make them vulnerable:

- Stennack Surgery was involved in the development of a local Frailty Clinic to provide assessment, diagnostics and early intervention to support care closer to home. A community coordinator actively helped to prevent hospital admissions of the most vulnerable patients by linking with the clinical and community resources accessed from the practice.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers, those with a learning disability. Those identified as severely frail were reviewed weekly on the vulnerable adult register.
- Those identified as vulnerable, including carers, were provided with timely access to care and treatment via a direct telephone number.
- There was a dedicated learning disabilities lead GP and nurse practitioner who ensured that all patients on the learning disability register received an annual health check. Practice nurses worked closely with the learning disability nurse specialist to ensure patients communication needs were met. Staff were able to access makaton and easy read information to engage with patients.
- Longer appointments were arranged for patients who were vulnerable and at a time to suit their needs. For example, some older patients with long term conditions needed appointments later in the day with their carer.
- Systems were in place to access interpreting services if they were indicated.
- Chaperone services were available including both male and female chaperones.
- The practice had systems to support carers including nominated carers' leads, a carers' events in the community hub. This included pop up cafes where advice and support about benefits, housing or social networking could be discussed in the waiting room.
- The practice had further developed its social prescribing approach by enabling patients to access support, exercise and other healthy living advice from local voluntary and community resources, which includes or have planned: Yoga. Pilates. Nordic walking for health. A

Are services responsive to people's needs?

gardening club run by a retired GP to create a sensory garden onsite. At the time of the inspection, 20 patients were regularly using these services with GPs receiving monthly updates about their progress. The patient participation group reported this number was increasing each week.

- Some GPs were trained to provide addiction recovery services through shared care arrangements with other health and third sector agencies. An alcohol home detoxification service was due to start soon after the inspection, which would enable patients to remain at home instead of being admitted to hospital for this aspect of their treatment. The practice hosted Addaction counselling services for patients with drug and alcohol related issues two days per week at Stennack Surgery. An Outlook South West counsellor provided additional care and support for patients.
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People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- Patients were signposted to local talking therapy services, which the practice hosted onsite.
- There was evidence that GPs provided weekly telephone consultations for patients with mental health needs who were awaiting input from mental health services. Monthly review meetings of patients with complex mental health needs were held at the practice with the community mental health team.

Timely access to care and treatment

Patients were able to access flexible care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays for same day and pre-bookable appointments and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised according to clear protocols for reception and clinical staff.
- Patients reported that the appointment system was easy to use and had improved. GP partners were transparent with the patients registered with them about the challenges faced at the practice. Over the previous 12 months, including the period of the last GP survey, there had been significant staffing challenges due to re-location and retirements of GPs and nurses. Communication was ongoing with patients who said they felt listened to and access increased through active signposting and new staff appointments with a wider skills mix.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously, actively reviewed and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as driver improve the quality of care in partnership with patients who participated in reviewing trends and discussion of solutions.

Please refer to the evidence tables for further information.

Outstanding ☆

Are services well-led?

We rated the practice outstanding for providing a well-led service.

The practice was rated as outstanding for well-led because:

- Despite some significant challenges in the last few years the leadership had demonstrated resilience and commitment to their patients and the wider community. They had continued to implement the strategy with the delivery of objectives that were stretching, challenging and innovative. A systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money.
- Governance and performance management arrangements continued to be proactively reviewed and reflect current best practice.
- Leaders had an inspiring shared purpose, strived to deliver and motivated staff to succeed.
- There were high levels of staff satisfaction, with a very low turnover other than retirement. Staff were proud of the organisation as a place to work and spoke highly of the open culture.
- There were consistently high levels of constructive staff engagement, being actively encouraged to raise, discuss and learn from complaints.
- There was strong collaboration and support across all staff and a common focus on improving quality of care and people's experiences.
- Innovative approaches continued to be used to gather feedback from people who used services and the public.
- The leadership drove continuous improvement at the practice and in the wider locality with staff accountable for delivering change. Safe innovation was celebrated to seek out and embed new ways of providing care and treatment and share these with all stakeholders.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them in line with the practice business strategy. For example, in recognition of national and local challenges recruiting GPs the practice reviewed the skill mix and diversified roles. It had recruited an advanced nurse practitioner, nurse prescribers, paramedic, clinical pharmacist and medicines technician for the practice since the last inspection in 2015.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.
- There was effective leadership and financial management at Stennack Surgery compared with the Cornwall averages in 2017. Stennack Surgery was below the locality averages and had saved money for the NHS for the following: Emergency Department attendance (26% reduction), in-patient Activity (16% reduction), Outpatient Activity (5% reduction), prescribing was below the expected budget (Penwith Locality GP Dashboard.

Vision and strategy

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

- The GP partnership had invested significantly and purchased the premises outright in 2017, providing them with greater control over the use, refurbishment and development of a community hub.
- There was a clear vision and set of values. These were to provide quality patient care based on: respecting others, working as a team, embracing change, being an effective business, having effective leadership and patient focussed. Patients and staff owned these values, providing critical challenges through feedback systems.
- The practice had a realistic five-year strategy and supporting business plans to achieve priorities. It had successfully applied for and been awarded funding for projects such as the childhood immunisation project to increase uptake in hard to reach families.
- The strategy drove locality health and social care priorities in Penwith and across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy continuously at business meetings and had an annual planning ahead each year.

Culture

Outstanding ☆

Are services well-led?

Leaders had an inspiring shared purpose based on a quality improvement approach. They strived to deliver this and motivated staff to succeed.

- Staff interviewed or responded in a survey verified they shared the vision of the practice to provide high quality care. We saw examples of staff using additional skills and contacts to provide high quality information for patients or guidance for staff
- Staff consistently stated they felt respected, supported and valued. They were proud to work in the practice and wanted to go the extra mile for patients.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values in the practice competency framework.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Several examples were seen, including being open and transparent with patients about the challenges faced during a period of staff instability. Patients were then engaged in developing the active signposting approach and raising awareness of this with patients when 19 new staff with diverse skills and experience joined the team. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us their leaders were dynamic and they were consistently able to raise concerns and were encouraged to do so. They had confidence that these would be addressed and shared examples with us such as being able to work flexibility to achieve a work life balance.
- There were processes for providing all staff with the development they need. This included regular appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. The practice was focussed on succession planning with a large number of staff undertaking advanced qualifications to develop skills and experience. For example, practice nurses being supported to complete the independent prescribing or nurse practitioner qualifications.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally and told us about reasonable adjustments put in place, including workload management and equipment to support people.
- There were positive relationships between staff and teams.

Governance arrangements

Governance and performance management arrangements were proactively reviewed and reflect current best practice.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care. GP partners held key roles on committees and provider groups such as the local medical council (LMC).
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. There was an organisational structure with roles and accountability information which all staff had access to. Two leaders were accountable for each key area.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient and staff safety. Performance and risk at the practice was discussed at weekly partners meeting. Any staff working part time were enabled to attend via skype.
- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints. Named staff held a register, which we saw, containing a list of all safety alerts, dissemination list, person accountable for any actions and verification of action taken.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.

Are services well-led?

- The practice had plans in place and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

Innovative approaches were used to gather feedback from people who use services and the public to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, the practice partners met with local residents, organisations, schools, the police and local councillors to obtain their views on shaping future health services.
- There was an active patient participation group involved in the connecting communities group to reduce social isolation and promote healthy living. The PPG worked in partnership with the practice to develop and raise awareness of community hub.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. A systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money. For example:

- Feedback from clinical commissioning group verified that Stennack Surgery practice continued to be at the forefront of several local initiatives within the primary care sector: The community hub was considered to be exemplar for other practices to implement. Multi-disciplinary team (MDT) meeting guidance was developed by NHS England in consultation with the Stennack Surgery practice. This tool and approach was shared with other practices as an exemplar.
- Safe innovation was celebrated. There was a clear proactive approach to seeking out and embedding new ways of providing care and treatment and sharing this with other stakeholders. Since the last inspection, the practice was proactive in adapting safeguarding meetings with all the local schools when key personnel such as the schools nurse and health visitor had left post. There was increased vigilance of vulnerable children and young people as a result seen in strongly positive feedback. Teachers highlighted the changes led by the safeguarding GP lead at the practice enabled them to consider more widely the impact of any safeguarding issues across families and siblings who may be at different schools, presenting differing or the same behaviours.
- The practice identified through auditing unplanned admissions that there were gaps affecting integration of care and support for vulnerable and socially isolated patients. The Penwith practices worked collaboratively as a locality and made a successful bid and secured funding for a Community Co-ordinator. This community co-ordinator will now be working across the three practices within the East Penwith Primary Care Home. This will lead to improved care and co-ordination for these vulnerable and isolated patients.
- The practice was focussed on integrating services bringing these closer to home for patients. Patient representatives gave strongly positive feedback about the range of services available at the practice, which had

positive outcomes for those who had a deprived background and limited access to funds or transport. The Friends of Stennack Surgery enabled the practice to be very well equipped with near patient testing equipment. Staff were equally well trained and competent to use this to benefit patients with early diagnosis, referral and treatment for suspected skin cancers.

- The practice continued to be an approved GP training practice providing placements for pre-qualification medical students and GPs in training. Deanery reports and feedback from students and registrars highlighted Stennack Surgery as being a supportive and inspiring environment to learn about patient care. Placements were also provided for nursing students.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared within the practice and wider locality and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance. For example, the practice manager represented the practice at the West Cornwall practice manager meetings and also an alliance meeting with other Penwith practices. She also recently represented the locality and helped to develop Active Signposting training for Penwith Practices and implement Improving Access within General Practice (IAGP) locally. She also recently represented the locality and helped to develop 'Active Signposting' training for Penwith practices and implementation of 'Improving Access within General Practice' (IAGP) locally.

Please refer to the evidence tables for further information

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these. We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation