Mevagissey Surgery

Quality Report

River Street
Mevagissey
St Austell
Kernow PL26 6UE
Tel: 01726 843701
Website: www.mevagisseysurgery.co.uk/

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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 service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Mevagissey Surgery was inspected on 3rd February 2015. This was a comprehensive inspection. Overall, we rated the practice as good.

Mevagissey Surgery provides primary medical services to people living in Mevagissey, Pentewan, Caerhayes, Gorran Haven, Sticker, Polgooth and St Austell. During the summer months the practice experiences a large influx of temporary residents. Mevagissey Surgery is situated in a rural coastal location. The practice also had a dispensary. A dispensing practice is where GPs are able to prescribe and dispense medicines directly to patients who live in a rural setting which is a set distance from a pharmacy.

At the time of our inspection there were approximately 4,953 patients registered at the service with a team of three GP partners and one GP registrar. GP partners held managerial and financial responsibility for running the business. In addition there was a practice manager, nurses, health care assistants, dispensary staff together with administrative and reception staff.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives.

Our key findings were as follows:

We rated this practice as good. Patients reported having good access to appointments at the practice and liked having a named GP which improved their continuity of care. The practice took into account the cultural needs of the local area. Patients could identify themselves as being Cornish on patient records and questionnaires. The practice was clean, well-organised, had good facilities and was well equipped to treat patients. There were effective infection control procedures in place.

The practice valued feedback from patients and acted upon this. Feedback from patients about their care and treatment was positive. We observed a patient centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Views of external stakeholders were positive and were aligned with our findings.

Summary of findings

The practice was well-led and had a clear leadership structure in place whilst retaining a sense of mutual respect and team work. There were systems in place to monitor and improve quality and identify risk and systems to manage emergencies.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of a patient's mental capacity to make an informed decision about their care and treatment, and the promotion of good health.

Suitable staff recruitment, pre-employment checks, induction and appraisal processes were in place and had been carried out. Staff had received training appropriate to their roles and further training needs had been identified and planned.

Information received about the practice prior to and during the inspection demonstrated the practice performed comparatively well with all other practices within the clinical commissioning group (CCG) area.

Patients told us they felt safe in the hands of the staff and felt confident in clinical decisions made. There were effective safeguarding procedures in place.

Significant events, complaints and incidents were investigated and discussed. Learning from these events was communicated and acted upon.

There were areas of practice where the provider needed to make improvements.

The provider should:

Consider arrangements for monitoring room temperatures in rooms where medicines are stored to ensure the integrity of those medicines. The minimum and maximum range of fridge temperatures should also be recorded in writing for the same reason.

We found examples of outstanding practice. These included

To address the significant care gap left by restrictions to the local community nurse team, the practice deployed their own practice nurses to patient's own homes. Elderly and vulnerable patients received home visits from the practice nurses and from practice GPs. This went beyond the contractual obligations of the practice.

Nurses at the practice carried out combined chronic disease management appointments to include all conditions experienced by one patient. This facilitated fewer appointments and was very convenient for the patient. The practice nurses also visited families in their own homes if they had suffered bereavement to offer emotional support.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated good for being safe. Patients we spoke with told us they felt safe, confident in the care they received and well cared for

The practice had systems to help ensure patient safety and staff had appropriately responded to emergencies.

Recruitment procedures and checks were completed as required to help ensure that staff were suitable and competent. Risk assessments had been undertaken to support the decision not to perform a criminal records check for administration staff.

Significant events and incidents were investigated both informally and formally. Staff were aware of the learning and actions taken. For example, a significant event involving end of life care showed that exemplary care had been provided and best practice from the event shared with other staff at meetings.

Staff were aware of their responsibilities in regard to safeguarding and the Mental Capacity Act 2005. There were suitable safeguarding policies and procedures in place that helped identify and protect children and adults from the risk of abuse. There was a lead GP for safeguarding and child protection.

There were suitable arrangements for the efficient management of medicines within the practice.

Relevant policies had been updated within the last 12 months.

The practice was clean, tidy and hygienic. Suitable arrangements were in place to maintain the cleanliness of the practice. There were systems in place for the retention and disposal of clinical waste.

Are services effective?

Good

The practice is rated good for being effective. Supporting data obtained both prior to and during the inspection showed the practice had effective systems in place to make sure the practice was efficiently run.

The practice had a clinical audit system in place and three recent clinical audits had been completed. These included a minor surgery audit and a medicines audit. These audits were repeated through the year, demonstrating a full audit cycle was in place.

Summary of findings

Care and treatment was delivered in line with national best practice guidance. The practice worked closely with other services to achieve the best outcome for patients who used the practice. For example, the practice had close liaison with dementia care nurses and with local care and nursing homes to support patients there.

Information obtained both during and after the inspection showed staff employed at the practice had received appropriate support, training and appraisal. GP partner appraisals and revalidation had been completed.

The practice had extensive health promotion material available within the practice and on the practice website.

Are services caring?

Good

The practice is rated as good for being caring. Data showed patients rated the practice higher than others for many aspects of care. Feedback from patients about their care and treatment was consistently positive.

We observed a patient centred culture and found evidence that staff were motivated to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patients' choices and preferences were valued and acted on.

Patients spoke positively about the care provided at the practice. Patients told us they were treated with kindness, dignity and respect. Patients told us how well the staff communicated with them about their physical, mental and emotional health and supported their health education.

Patients told us they were included in the decision making process about their care and had sufficient time to speak with their GP or a nurse. They said they felt well supported both during and after consultations.

Are services responsive to people's needs?

Good

The practice was rated good for being responsive. Patients commented on how well all the staff communicated with them and praised their caring, professional attitudes.

Patients told us the staff listened to them and responded promptly to meet their needs. There was information provided on how patients could complain although access to this information on the practice website could be improved. Complaints were managed according to the practice policy and within reasonable timescales.

The practice recognised the importance of patient feedback and had encouraged the development of a patient participation group to gain patients' views.

Summary of findings

Practice staff had identified that not all patients found it easy to understand the care and treatment provided to them and made sure these patients were provided with relevant information in a way they understood. There was a hearing aid induction loop and large print leaflets available at the practice.

Patients said it was usually easy to get an appointment at the practice and were able to see a GP on the same day if it was urgent. However, one patient reported that they sometimes had to wait up to two weeks to get a routine appointment with a GP of their choice.

Are services well-led?

Good

The practice had a clear vision which had quality and patient safety as its top priority.

The practice is rated as good for being well led. The practice had a vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. Nursing staff, GPs and administrative staff demonstrated they understood their responsibilities including how and to whom they should escalate any concerns.

Staff spoke positively about working at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work.

The practice had a number of policies to govern the procedures carried out by staff and regular governance meetings had taken place. There was a programme of clinical audit in operation with clinical risk management tools used to minimise any risks to patients, staff and visitors.

Significant events, incidents and complaints were managed as they occurred and through a more formal process to identify, assess and manage risks to the health, welfare and safety of patients. The practice used significant event reporting to include events which had gone well particularly well, in order to share best practice with all staff and with other practices.

The practice sought feedback from patients, which included using new technology, and had an active patient participation group (PPG) who met with us during our inspection.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for providing care to older people.

Older patients are well represented in the practice population; the number of patients aged over 75 is higher than the national average. The practice is conscious that this population group tends to have more complex needs and be on more medication. The practice took into account that this population group may also be less able to access health care and are at increasingly at risk of financial hardship.

Patients in this population group had a named GP for continuity of care.

The practice had carried out regular audits looking specifically for unmet needs in the elderly and prescribing in this population group. Nurses and GPs at this practice carried out a higher number of home visits rate than other comparable practices in the Kernow Clinical Commissioning Group. The practice stated that they had a low threshold for carrying out home visits due to the rural nature of the area, the poor public transport links and the large numbers of patients in this population group.

GPs at the practice email each other when they encounter anyone with a significant diagnosis to help keep care coordinated. Practice staff also telephone patients on receiving their hospital discharge summaries to check all is well and make sure that Multi-Disciplinary Team (MDT) meetings are regular and minuted. These MDT meetings include representatives from social services to ensure a joined up approach to patient care.

Practice nurses provide coordinated care by carrying out above average numbers of home visits. The practice nurses also filled the gap left by a restricted district nursing service by carrying out blood tests when needed at short notice, chronic disease checks, medicines monitoring, vaccinations and bereavement support.

The practice liaised with other agencies to support this population group. Age concern provided a chiropody clinic every week in the practice. The local church and community groups enjoyed close links with the practice to support this population group in communal gatherings for mutual support and socialisation.

The practice has a high visiting rate especially for the elderly. This combined with utilising practice nurses to do visits for frail elderly, domiciliary flu injections, chronic disease and bereavement visits is an example of best practice.

Summary of findings

People with long term conditions

Good

The practice is rated as good for providing care to people with long term conditions.

Many patients at the practice have a number of parallel long term conditions. The practice has a community matron to help monitor and manage this population group on a weekly basis.

The practice has implemented specialist clinics for this population group. This has assisted in both providing support for patients and in reducing the number of visits patients need to make over the course of a year. This assisted in improving the efficiency of the services offered by the Surgery.

The practice has been involved in the Living Well project in Cornwall which suggests that a pragmatic approach looking less at medical outcomes and more at what people can actually do may be more useful to patients.

As a result of this work the practice places an emphasis on longer appointments, good quality multidisciplinary meetings and referral to services near home to improve outcomes for patients in this population group.

Patients with complex conditions are added to a specific GP partner only list to enable continuity where it is most needed. Practice nurses hold weekly Coronary Heart Disease, diabetes and COPD clinics. The practice diabetes lead nurse has regular input from a specialist consultant on diabetes. The practice had regular liaison with the palliative care nurse and the heart failure nurse to discuss changing patient needs and updates on any best practice. The practice palliative care list is reviewed at monthly meetings.

Families, children and young people

Good

The practice is rated as good for families, children and young people.

The practice has close links with the local midwifery team. Feedback from the midwife team stated that the practice went beyond contractual obligations by offering 24 hour baby checks at home for new mothers, because of how difficult it can be to get out with a new baby.

The practice staff paid attention to when parents can bring in their children and accommodated work and school time commitments with suitably timed appointments.

The practice stressed the importance of providing appropriate services for young people. The practice had attained an EEFO kite mark level 1 for engaging with young people and plans were in place to improve this to level 2. EEFO kite marks a services that meets

Summary of findings

young person friendly quality standards across Cornwall and the Isles of Scilly. The term EEFO is not an abbreviation. EEFO is a word that has been designed by young people, to be owned by young people.

The practice offered a low threshold for seeing children whose parents are concerned and offering an open door in the event that they need further review.

The practice invited the local health visitor and school nurses to their monthly multi-disciplinary team meeting to discuss children or families where there is clinical or social concern.

The practice was aware that issues around privacy and confidentiality are often important for young people. The practice had looked at the possibility of providing appointments at alternative venues away from the practice.

A full range of child vaccinations was available from the practice. Family planning clinics and contraceptive services were also available.

Working age people (including those recently retired and students)

Good

The practice is rated as good for providing care to working age people. The practice provided appointments on the same day. If these appointments were not available then a telephone consultation with a GP would be booked and extended practice hours would accommodate the patient if needed to be seen. Patients could book appointments and repeat medications on line.

The practice offered regular evening surgeries between 6.30pm and 8pm specifically for patients in this population group, although they could also be taken up by other patients as necessary. Wherever possible the practice fitted appointments around peoples' working commitments.

A great deal of written positive feedback was in evidence from summer periods when working age people had their holidays. During the summer when Mevagissey experiences an influx of temporary residents there is a significant increase in demand placed upon the practice. The practice planned for this contingency to ensure that standards were maintained. Cleanliness, easy access to appointments and the attitude of staff had been praised and comparisons with temporary resident's home practices were very positive. This feedback often reflected the availability of on the day triage appointments at the practice instead of waiting for routine slots.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for people whose circumstances may make them vulnerable. The practice had a vulnerable patient register to identify these patients. Vulnerable patients were reviewed at the multidisciplinary team meetings.

Staff told us that there were no patients who had a first language that was not English, however, interpretation requirements were available to the practice and staff knew how to access these services. This service could also be accessed during the busier summer months with its influx of temporary residents, not all of whom may speak English.

Patients with learning disabilities were offered and provided a health check every year during which their long term care plans were discussed with the patient and their carer if appropriate. Reception staff were able to identify vulnerable patients and offer longer appointment times where needed and send letters for appointments.

The practice had identified local hard to reach groups whose circumstances may make them vulnerable. This included patients who are reluctant to attend the practice. The local public health team in liaison with the practice had offered a series of Fishermen's medicals.

Mevagissey practice was not aware of problems with homelessness or travellers in the area but alcoholism and drug dependence is present and sometimes difficult to address. The practice was working to improve drug and alcohol services in future through the attainment of further staff training in alcohol and drug management.

Where there are concerns over vulnerability or safeguarding, patient's needs are discussed at the monthly multi-disciplinary team meeting where input from social services or local support organizations was valued.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for providing care to people experiencing for mental health.

The practice hosted support services for patients with poor mental health in one of their treatment rooms as well as providing health checks for their carers. Any missed appointments were reviewed. There was signposting and information available to patients. The practice referred patients who needed mental health services as well as support services being provided at the practice.

Summary of findings

GPs from the practice attended multi-disciplinary team meetings every month. This is a dedicated hub meeting attended by a psychiatrist, community mental health services and a local counselling service. Patients suffering poor mental health were offered annual health checks and testing for depression and anxiety as recommended by national guidelines. GPs and nurses had training in the Mental Capacity Act (MCA) 2005 and had an understanding of the act or appropriate guidance was available in relation to the Act when caring for patients with Dementia.

The practice identified that dementia brings additional challenges for the carer and wider family, making co-ordination a priority which can be difficult with regular changes of staff, for example in the dementia practitioner service.

The practice stated that early detection of dementia is now being incentivized by the NHS which may enable earlier introduction of support systems. Staff at the practice considered the spouses and family of those affected by dementia and offered them priority access. This is taking into account their increased risk of anxiety and depression which was explored in a practice questionnaire. The practice maintained an up to date carers' register which was used to offer communal meetings and support for carers.

One of the GP partners at the practice has an interest in mental health with a diploma in primary care mental health. There was a register of patients with mental health issues. GPs kept regular contact with these by telephone review. Practice staff shared a commitment to supportive and holistic management of patients in this population group.

The practice stated that their easily approachable access to GPs meant that anyone in the community or healthcare team can voice their concerns from chemist to dispenser or community warden with quick access to duty GP who can arrange an urgent assessment.

Due to the small patient list and stable population with a long serving staff group the practice was able to provide flexible care according to the patient's needs.

Summary of findings

What people who use the service say

We spoke with 15 patients during our inspection. We spoke with a representative of the patient participation group (PPG).

The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected 17 comment cards. Of these, 13 contained very positive comments. Negative comment cards remarked upon the parking problems experienced in using the practice. The practice is situated at the far end of a Cornwall Council pay and display car park. There are no concessions for patients attending the practice. This matter was outside of the control of the practice.

Patients were very positive about the service provided and the attitudes of all the staff. They felt that they were lucky to have this practice and many felt it was the best in Cornwall. Patients stated that referrals to specialist services were prompt when needed and followed through.

Patients referred to the end of life care delivered by the practice as excellent. GPs and staff at the practice provided emotional support to families and referred them for bereavement counselling.

Although the majority of patients were satisfied with the ease of getting a routine appointment, some patients stated that the length of time it took to get a routine appointment could be improved.

These findings were reflected during our conversations with patients and discussion with the PPG members. The feedback from patients was positive. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients stated they were happy, very satisfied and said they received good treatment. Patients told us that the GPs were professional, kind and attentive.

Patients were happy with the appointment system and said it was easy to make an appointment. They told us that the practice had installed a new telephony system which made it easier to get through to the practice. Patients appreciated the service provided and told us they had no complaints but knew how to complain should they wish to do so.

Patients were satisfied with the facilities at the practice. Patients commented on the building being clean and tidy. Patients told us staff used gloves and aprons where needed and washed their hands before treatment was provided.

Patients found it easy to get repeat prescriptions and said they thought the website was informative. Patients told us they liked the visual display unit in the waiting room which provided useful information about a range of clinics, health services and advice.

The 2014 GP Patient Survey showed that of 123 respondents, 96% had confidence and trust in the last GP they saw or spoke to. This was higher than the national average.

Areas for improvement

Action the service SHOULD take to improve

The practice should consider arrangements for monitoring room temperatures in rooms where medicines are stored to ensure the integrity of those medicines. The minimum and maximum range of fridge temperatures should also be recorded in writing for the same reason.

Outstanding practice

To address the significant care gap left by restrictions to the local community nurse team, the practice deployed

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their own practice nurses to patient's own homes. Elderly and vulnerable patients received home visits from the practice nurses and from practice GPs. This went beyond the contractual obligations of the practice.

Nurses at the practice carried out combined chronic disease management appointments to include all conditions experienced by one patient. This facilitated fewer appointments and was very convenient for the patient. The practice nurses also visited families in their own homes if they had suffered bereavement to offer emotional support.

Mevagissey Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor, a practice nurse specialist adviser and an expert by experience.

Background to Mevagissey Surgery

Mevagissey Surgery provides primary medical services to people living in Mevagissey, Pentewan, Caerhayes, Gorran Haven, Sticker, Polgooth and St Austell. During the summer months the practice experiences a large influx of temporary residents. Mevagissey Surgery is situated in a rural coastal location. The practice also had a dispensary. A dispensing practice is where GPs are able to prescribe and dispense medicines directly to patients who live in a rural setting which is a set distance from a pharmacy.

At the time of our inspection there were approximately 4,953 patients registered at the service with a team of three GP partners and one GP registrar. GP partners held managerial and financial responsibility for running the business. In addition there was a practice manager, and administrative and reception staff. In addition there was a practice manager, nurses, health care assistants, dispensary staff together with administrative and reception staff.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives.

Mevagissey Surgery is open on Mondays 8.30am to 6.30pm and on Tuesdays to Fridays 8am to 6.30pm. The phone lines are operational from 8.30am each morning. Once a week the practice is open late 6.30pm to 8.30pm. This evening varies from week to week.

Outside of these hours a service is provided by another health care provider by patients dialling the national 111 service.

Routine appointments are available daily and are bookable up to three weeks in advance. Urgent appointments are made available on the day and telephone consultations also take place.

Mevagissey Surgery provides regulated activities from the main practice at Mevagissey Surgery, River Street, Mevagissey, Kernow PL26 6UE and from a small branch at Old Lime Kiln, Gorran Haven, St Austell, Kernow PL26 6JJ. The main site was visited during this inspection.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

How we carried out this inspection

Before visiting Mevagissey Surgery we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, the local clinical commissioning group and local voluntary organisations.

We requested information and documentation from the provider which was made available to us either before, during or 48 hours after the inspection.

We carried out our announced visit on 3rd February 2015. We spoke with 15 patients and we also spoke with a representative from the patient participation group (PPG). We collected 17 patient responses from our comments box which had been displayed in the waiting room. We obtained information from and spoke with the practice manager, GPs, receptionists and clerical staff, practice nurses and health care assistants. We observed how the practice was run and looked at the facilities and the information available to patients.

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Good

Are services safe?

Our findings

Safe Track Record

The practice had a system in place for reporting, recording and monitoring significant events.

The practice kept records of significant events that had occurred and these were made available to us.

We looked at the minutes of a significant event meeting from July 2014 to confirm a safe track record was discussed.

There was evidence that appropriate learning had taken place where necessary and that the findings were communicated to relevant staff. For example, where patients with serious conditions had not attended the practice for three months, practice staff carried out proactive computer based searches to detect this and allow a GP to contact them and offer support.

Staff were aware of the significant event reporting process and how they would verbally escalate concerns within the practice. All staff we spoke with felt very able to raise any concern however small. Staff knew that following a significant event, the GPs undertook an analysis to establish the details of the incident and the full circumstances surrounding it. Staff explained that these monthly meetings were well structured, well attended and not hierarchical.

There were systems in place to make sure any medicines alerts or recalls were actioned by staff.

The practice manager emailed this information to staff and maintained a computer based and a paper based register of these, which were available to all staff. These were also discussed at team meetings.

Learning and improvement from safety incidents

At Mevagissey Surgery the process following a significant event or complaint was both informal and formalised. GPs discussed incidents daily and also monthly at clinical meetings. GPs, nurses and practice staff were able to explain the learning from these events.

Significant event reports are typed up by the reporter, which is usually a GP but could be any member of staff. These events are discussed at monthly partner's meetings and comments and actions recorded.

Reliable safety systems and processes including safeguarding

Patients told us they felt safe at the practice and staff knew how to raise any concerns. A named GP had a lead role for safeguarding older patients, young patients and children. The practice safeguarding lead GP possessed the appropriate high level of safeguarding training. Other GPs were either at level three safeguarding training or working towards it.

There were appropriate policies in place to direct staff on when and how to make a safeguarding referral. The policies included information on external agency contacts, for example the local authority safeguarding team. These details were displayed where staff could easily find them. All staff had received online safeguarding training on an annual basis.

There were monthly multidisciplinary team meetings with relevant attached health professionals including social workers, district nurses, palliative care, physiotherapist and occupational therapists where vulnerable patients or those with more complex health care needs were discussed and reviewed. Health care professionals were aware they could raise safeguarding concerns about vulnerable adults at these meetings. There was a Mental Capacity Act 2005 (MCA) policy in place and staff had received MCA training. The MCA is a legal framework which protects patients who need support to make important decisions.

The computer based patient record system allowed safeguarding information to be alerted to staff in a discreet way. When a vulnerable adult who was sleeping rough had been seen by different health professionals, staff were aware of their circumstances. Staff demonstrated knowledge of how to make a patient referral or escalate a safeguarding concern internally using the whistleblowing policy or safeguarding policy.

We discussed the use of chaperones to accompany patients when consultation, examination or treatment were carried out. A chaperone is a member of staff or person who acts as a witness for a patient and a medical practitioner during a medical examination or treatment. Patients were aware they were entitled to have a chaperone present for any consultation, examination or procedure where they feel one is required. All reception staff had received appropriate training on being a chaperone.

Good

Are services safe?

The practice had a written policy and guidance for providing a chaperone for patients which included expectations of how staff were to provide assistance. Staff understood their role was to reassure and observe that interactions between patients and doctors were appropriate and record any issues in the patient records. Signs indicating there was a chaperone service available were on display to patients.

Medicines Management

We checked medicines stored in the dispensary and found they were stored securely and were only accessible to authorised staff. The temperature in the medicines refrigerator was monitored. However, the full temperature range (maximum and minimum) was not being recorded. At the time of our inspection the temperature in the dispensary was within the recommended temperature range for storing medicines. However, there were no written records of temperature monitoring kept. Systems were in place to check that medicines were within their expiry date and suitable for use. Expired and unwanted medicines were disposed of in line with waste regulations.

There were clear operating procedures in place for dispensary processes. Systems were in place to ensure all prescriptions were signed before being dispensed. The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. Any errors or near misses were recorded, monitored and actions put in place to reduce the risks of any recurrence.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Handwritten prescription forms (FP10s) are correctly checked in to the safe and out to GPs by serial numbers. Printer copies of FP10s are checked into the practice by serial number but no record is kept when distributed to GP printers. We found one GP consultation room where blank prescription pads and printer forms were stored insecurely. These forms should be recorded when received and used, to enable an audit trail to be maintained of the whereabouts of these forms. This was immediately rectified during our visit.

We saw records showing that dispensary staff had received appropriate training and had regular checks and appraisals of their competence.

The practice had established a weekly home delivery service for patients who were unable to collect their prescriptions from the surgery.

GPs do not carry controlled drugs as a matter of routine in their bags but may take some from the dispensary if going on a visit where their use may be needed. Other drugs in GP's bag are regularly checked by dispensary staff every three months. GPs carried an appropriate range of drugs. Written procedures were in place to check expiry dates. However, GPs need to ensure they lock their rooms when these bags are left within an unoccupied room. This was immediately rectified during our visit.

The control of repeat prescriptions was managed well. Patients were not issued any medicines until the prescription had been authorised by a GP. Patients were satisfied with the repeat prescription processes. They were notified of health checks needed before medicines were issued. Patients explained they could use the box in the surgery, send an e-mail, or use the on-line request facility for repeat prescriptions.

Cleanliness & Infection Control

We left comment cards at the practice for patients to tell us about the care and treatment they receive. We received 17 completed cards. Of these, 10 specifically commented on the building being clean, tidy and hygienic. Patients told us staff used gloves and aprons and washed their hands.

The practice had policies and procedures on infection control. These had been reviewed in November 2014. Annual audits were in place. We spoke with the infection control lead nurse. Staff had access to supplies of protective equipment such as gloves and aprons, disposable bed roll and surface wipes. The nursing team were aware of the steps they took to reduce risks of cross infection and had received updated training in infection control.

Good

Are services safe?

Treatment rooms, public waiting areas, toilets and treatment rooms were visibly clean. There was a cleaning schedule carried out and monitored. There were hand washing posters on display to show effective hand washing techniques.

Clinical waste and sharps were being disposed of in safely. There were sharps bins and clinical waste bins in the treatment rooms. The practice had a contract with an approved contractor for disposal of waste. Clinical waste was stored securely in a dedicated secure area whilst awaiting its collection from a registered waste disposal company.

Equipment

Emergency equipment available to the practice was within the expiry dates. The practice had a system using checklists to monitor the dates of emergency medicines and equipment so they were discarded and replaced as required.

Equipment such as the weighing scales, blood pressure monitors and other medical equipment were serviced and calibrated where required.

Portable appliance testing (PAT) where electrical appliances were routinely checked for safety was last carried out by an external contractor in May 2014.

Staff told us they had sufficient equipment at the practice.

Staffing & Recruitment

There were five GPs at the practice, one practice manager, three nurses, two health care assistants, one IT specialist, five dispensary staff, seven administration staff and one cleaner. Staff told us there were always suitable numbers of staff on duty and that staff rotas were managed well.

The practice had a low turnover of staff. The practice said they used locums as staff cover but tried to use the same one for continuity. GPs told us they also covered for each other during shorter staff absences. One GP was off sick during our visit. There was a locum GP covering for this. There was also a registrar GP working at this training practice alongside experienced GPs.

The practice used a team approach where the workload for part time staff was shared equally. Each team had appointed clerical support. Staff explained this worked well but there remained a general team work approach where all staff helped one another when one particular member of staff was busy.

Recruitment procedures were safe and staff employed at the practice had undergone the appropriate checks prior to commencing employment. Clinical competence was assessed at interview. Once in post staff completed an induction which consisted of ensuring staff met competencies and were aware of emergency procedures.

Criminal record checks via the disclosure barring service (DBS), were performed for GPs, nursing staff and administrative staff who had direct access with patients. Recorded risk assessments had been performed explaining why some clerical and administrative staff had not had a criminal records check.

The practice had appropriate disciplinary procedures to follow should the need arise.

Each registered nurse Nursing and Midwifery Council (NMC) status was completed and checked annually to ensure they were on the professional register to enable them to practice as a registered nurse.

Monitoring Safety & Responding to Risk

The practice had a suitable business continuity plan in place that documented the practice's response to any prolonged events that may compromise patient safety. For example, this included extreme weather conditions, computer loss and lists of essential equipment. The practice had a small sub branch at Gorran Haven in addition to the main site at Mevagissey. This could be temporarily utilised as the main site in the event of adverse events. The plan had been reviewed in March 2014 and was updated annually. Staff had paper copies of the plan.

Nursing staff received any medical alert warnings or notifications about safety by email or verbally from the GPs or practice manager. There was a computerised and a paper based system for this which could be easily accessed by staff.

There was a system in operation to ensure one of the nominated GPs covered for their colleagues when necessary, for example home visits, telephone consultations and checking blood test results.

Arrangements to deal with emergencies and major incidents

Appropriate equipment was available and maintained to deal with emergencies, including if a patient collapsed. Administration staff appreciated that they had also been

included on the basic life support training sessions. The practice had an automated external defibrillator (AED) which is a resuscitation device to assist patients who experience a cardiac arrest.

All staff received a refresher training package on emergency first aid and life support on a three yearly basis. Clinical staff received this training on an annual basis.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

There were examples where care and treatment followed national best practice and guidelines. For example, emergency medicines and equipment held within the practice followed the guidance produced by the Resuscitation Council (UK). The practice followed the National Institute for Health and Care Excellence (NICE) guidance and had formal meetings to discuss latest guidance. Where required, guidance from the Mental Capacity Act 2005 had been followed. Guidance from national travel vaccine websites had been followed by practice nurses.

The practice used the quality and outcome framework (QOF) to measure their performance. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF data for this practice showed they generally achieved higher than national average scores in areas that reflected the effectiveness of care provided. The local Kernow clinical commissioning group (KCCG) data demonstrated that the practice performed well in comparison to other practices within the KCCG area. For example, there had been an improvement in flu vaccination rates for patients over 65 years from 59% to 62% in the last twelve months.

Management, monitoring and improving outcomes for people

The practice told us they were keen to ensure that staff had the skills to meet patient needs and so nurses had received training including immunisation, diabetes care, cervical screening and travel vaccinations.

GPs in the practice undertook minor surgical procedures and joint injections in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. There was evidence of regular clinical audit in this area which was used by GPs for revalidation and personal learning purposes.

The practice has a high visiting rate especially for the elderly. This combined with utilising practice nurses to do visits for frail elderly, domiciliary flu injections, chronic disease and bereavement visits is an example of best practice.

The practice offers extended hour appointments one evening per week. The practice has carried out an audit of patients' awareness of Out of Hours contact details and have responded to the lack of awareness by including details in communication with their 2% high risk patients. The practice has addressed this by displaying Out of Hours contact details on their visual display unit which plays in the waiting room.

Urgent cases were seen on the same day and calls were triaged by the duty GP. Visit requests were discussed and shared at the daily morning coffee meetings.

Effective Staffing

All of the GPs in the practice participated in the appraisal system leading to revalidation of their practice over a five-year cycle. The GPs we spoke with told us and demonstrated that these appraisals had been appropriately completed.

Staff were very passionate about working at the surgery and supporting one another. Staff told us that if things do go wrong they deal with it with the Practice Manager who is extremely supportive. Staff told us that when they had any suggestions on making improvements to the service provided they felt confident to putting their views across to the manager. There was evidence that this was discussed at the monthly practice meetings.

The practice was a teaching practice for new GPs. There were trainer GPs at the practice who supported new GPs with their development. We spoke with a registrar GP at the practice who spoke very highly of the support they had received at the practice.

Nursing staff had received an annual formal appraisal and kept up to date with their continuous professional development programme, documented evidence confirmed this. A process was also in place which showed clerical and administration staff received regular formal appraisal.

There was a comprehensive induction process for new staff which was adapted for each staff role.

The staff training programme was monitored to make sure staff were up to date with training the practice had decided was mandatory. This included basic life support, safeguarding, fire safety and infection control. Staff said that they could ask to attend any relevant external training to further their development.

Good

Are services effective?

(for example, treatment is effective)

There was a set of policies and procedures for staff to use and additional guidance or policies located on the computer system.

Working with colleagues and other services

The practice worked effectively with other services. Examples given were minimal health services, health visitors, specialist nurses and community nursing. The practice had regular liaison with the local midwifery service who conducted a weekly clinic. Clinical staff met with the health visitor twice a month. Other joint working included a local charity which helped patients get back to work after an illness and working with national charities who provided services such as chiropody for older patients.

Once a month there was a multidisciplinary team meeting to discuss vulnerable patients, high risk patients and patients receiving end of life care. This included the multidisciplinary team such as physiotherapists, occupational therapists, health visitors, district nurses, community matrons and the mental health team.

Communication with the out of hours service was good as the Out of Hours GPs were able to access patient records with their consent, using a local computer system. The practice GPs were informed when patients were discharged from hospital. This prompted a medication review.

Information Sharing

The practice worked effectively with other services. Practice GPs met with mental health professionals twice a month to discuss patient care updates.

Other examples given were regular information sharing with mental health services, health visitors, specialist nurses, hospital consultants and community nursing staff. For example, the GPs shared relevant information with social services and the acute care team at home to provide patients with the most effective care possible.

Consent to care and treatment

Patients told us they were able to express their views and said they felt involved in the decision making process about their care and treatment. They told us they had sufficient time to discuss their concerns with their GP and said they never felt rushed. Feedback given on our comment cards showed that patients had different treatment options discussed with them, together with the positive or possible negative effects that treatment can have.

Staff had access to different ways of recording that patients had given consent to treatment. There was evidence of patient consent for procedures including immunisations, injections, and minor surgery. Patients told us that nothing was undertaken without their agreement or consent at the practice.

Where patients did not have the mental capacity to consent to a specific course of care or treatment, the practice had acted in accordance with the Mental Capacity Act (2005) to make decisions in the patient's best interest. Staff were knowledgeable and sensitive to this subject. We were given specific examples by the GPs where they had been involved in best interest decisions and where they had involved independent mental capacity assessors to ensure the decision being made regarding the patient who could not decide themselves, was in the patient's best interest.

GPs carried MCA prompt cards in their visiting bags. There was evidence that capacity issues were often discussed at monthly multi-disciplinary team meetings. GPs were aware of how to contact capacity advocates, and other MCA related support such as the power of attorney and determination of best interests.

Health Promotion and Prevention

There were regular appointments offered to patients with complex illnesses and diseases. The practice manager explained that this was so that patients could access care at a time convenient to them. A range of screening tests were offered for diseases such as blood tests, aneurism aortic screenings, which saved patients from having to visit hospital.

Vaccination clinics were organised on a regular basis which were monitored to ensure those that needed vaccinations were offered. Patients were encouraged to adopt healthy lifestyles and were supported by services such as gym referrals, weight management and smoking cessation clinics. Patients with diabetes were invited to a diabetes clinic where staff discussed how changes to lifestyle, diet and weight could influence their diabetes. The same support was in place for patients with coronary heart disease or chronic obstructive pulmonary disease (COPD). COPD is a serious lung disease that makes it harder to breathe. Both chronic bronchitis and emphysema are considered to be COPD.

Good

Are services effective?

(for example, treatment is effective)

All patients with learning disability were offered a physical health check each year. 100% of these had been completed by the practice.

Staff explained that when patients were seen for routine appointments, prompts appeared on the computer system to remind staff to carry out regular screening, recommend lifestyle changes, and promote health improvements which might reduce dependency on healthcare services.

The diabetic appointments supported and treated patients with diabetes which included education for patients to learn how to manage their diabetes through the use of insulin. Health education was provided on healthy diet and life style.

The practice recognised the need to maintain fitness and healthy weight management. GPs had referred patients to qualified physiotherapists and other services. Patients had also been referred to local leisure centres for exercise programmes.

There was a visual display unit in the waiting room which displayed information about the GPs and their clinical interests, how to manage your cholesterol, how to access the Friends of the Surgery, the PPG and notifying patients about practice news.

There were information stands well stocked with useful health related information. There was also a bookcase containing books on all sorts of health topics and conditions for patients to access. The practice had an easy to read version of their feedback form, together with other easy to read forms such as what to do if your home suffers flooding.

Family planning, contraception and sexual health screening was provided at the practice. The practice offered a travel vaccination service.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients told us they felt well cared for at the practice. They told us they felt they were communicated with in a caring and respectful manner by all staff. Patients spoke highly of the staff and GPs. We did not receive any negative comments about the care patients received.

We left comment cards at the practice for patients to tell us about the care and treatment they received. We collected 17 completed cards which contained positive comments. All comment cards stated that patients were grateful for the caring attitude of the staff who took time to listen effectively.

Patients were not discriminated against and told us staff had been sensitive when discussing personal issues.

Patient confidentiality had been improved by building work at the practice which had provided a new reception hatch and glass partition. No patient calls were made or taken at the reception desk. These were done from the back office to ensure confidentiality.

There was a low level reception desk for wheelchair users. Although there was a bell at the main reception desk, there was no bell provided at the low level reception desk.

The waiting areas had sufficient seating and were located away from the main reception desk which reduced the opportunity for conversations between reception staff and patients to be overheard. There were additional areas available should patients want to speak confidentially away from the reception area. We heard, throughout the day, the reception staff communicating pleasantly and respectfully with patients.

Conversations between patients and clinical staff were confidential and conducted behind a closed door. Window blinds, sheets and curtains were used to ensure patient's privacy. The GP partners' consultation rooms were also fitted with dignity curtains to maintain privacy.

We discussed the use of chaperones to accompany patients when consultation, examination or treatment were carried out. A chaperone is a member of staff or person who is present with a patient during consultation, examination or treatment. Posters displayed informed patients they were able to have a chaperone should they wish. Administration staff at the practice acted as chaperones as required. They had been received appropriate training. They understood their role was to reassure and observe that interactions between patients and doctors were appropriate.

The practice had achieved level one EEFO for treating young people with respect. EEFO is a scheme in Cornwall and the Isles of Scilly for promoting engagement with young people. EEFO is not short for anything, it is a term coined by young people, to be owned by young people. The practice was working towards achieving EEFO level two.

Care planning and involvement in decisions about care and treatment

Patients told us that they were involved in their care and treatment and referred to an ongoing dialogue of choices and options. Comment cards related patients' confidence in the involvement, advice and care from staff and their medical knowledge, the continuity of care, not being rushed at appointments and being pleased with the referrals and ongoing care arranged by practice staff.

Patients said that their GPs always discussed their treatment beforehand, set out the options available and provided them with an informed choice.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. We looked at the results of the 2014 GP Patient survey. This showed that 99% of the 123 respondents in the survey stated that they were listened to and treated with kindness. The patients we spoke to and the comment cards we received were consistent with this information.

Notices in the patient waiting room and patient website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us families who had suffered bereavement were contacted by their usual GP. GPs said the personal list they held helped with this communication. There was a counselling service available for patients to access.

Good

Are services caring?

The practice offered bereavement support to the families of patients. The practice is informed by email at 8.30am each day from the bereavement office, the hospice and the out of hours services if any patients have died.

GPs then telephone to arrange a visit that day for support to the family. If necessary GPs will also offer support from the bereavement counselling services. There are two services, one of which visits the practice twice a week.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients told us they felt the staff at the practice were responsive to their individual needs. They told us that they felt confident the practice would meet their needs. GPs told us that when home visits were needed, they were normally made by the GP who was most familiar with the patient.

The results of the 2014 GP Patient Survey were extremely positive about this area. Of 123 respondents, 80% usually waited 15 minutes or less after their appointment time to be seen. This was significantly better than the local KCCG average which was 69%.

The same survey showed that 89% of respondents described their experience of making an appointment as good. This was better than the KCCG average which was 82%.

Systems were in place to ensure any referrals, including urgent referrals for hospital care and routine health screening including cervical screening, were made in a timely way. Patients told us that any referral to secondary care had always been discussed with them.

Records showed that all patients who had been diagnosed with cancer had received a GP review within six months of their initial diagnosis. This met best practice.

An effective process was in place for managing blood and test results from investigations. GPs were on holiday the other GPs covered for each other and results were reviewed within 24 hours, or 48 hours if test results were routine. Patients said they had not experienced delays receiving test results.

A patient participation group (PPG) had been set up. Members of this group said they had already been consulted about changes at the practice, including the new visual display unit information screen. The PPG members said they were encouraged to contribute suggestions. For example, feedback from the PPG had led to the improvements listed below which showed how the practice had responded to and met people's needs in the waiting room.

There was comfortable, well maintained variations of seating to suit most people's needs. There was a small area containing an array of children's toys including a model railway and a variety of story books as well as a large tank of tropical fish. At the rear of the waiting room were large windows which overlooked a small courtyard containing plants and a large pool with a fountain in the middle. There were lots of pictures on the walls many from the local school and no piped music.

The practice has carried out an audit of patients' awareness of Out of Hours contact details. It was found that some patients were unaware of the Out of Hours service. The practice has addressed this by displaying Out of Hours contact details on their visual display unit which plays in the waiting room.

Information displayed on the visual display unit encouraged patients to offer feedback on any area they feel needs improving.

Tackle inequity and promote equality

All staff had received equality and diversity training in January 2015. The practice had recognised the needs of different groups in the planning of its services. Staff said no patient would be turned away.

There was a great deal of material available for patients with learning difficulties or who could not access the written word. The practice had sought and obtained guidance on this from the district nurses and other health and social care professionals on using this material. This included meeting with a patient and going through the information with them in order to prepare them for the examination or process they are going to have done at the surgery. For example, cervical smears. GPs had this material on their computers for ease of access.

The practice had an easy to read version of their feedback form, together with other easy to read forms such as what to do if your home suffers flooding.

The number of patients with a first language other than English in this rural coastal practice was very low. However, during the summer months there were sometimes visitors whose native language was not English. The practice staff knew how to access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

The patient participation group (PPG) was working to recruit patients from different backgrounds to reflect the various population groups which made up the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

There was no evidence of discrimination when making care and treatment decisions.

Access to the service

We looked at GP patient survey for 2014 which had 123 respondents. Of these, 96% of respondents found it easy to get through to this surgery by phone. This was higher than the local KCCG average which was 82%.

General access to the building was good. The practice had an open waiting area and sufficient seating. The reception and waiting area had sufficient space for wheelchair users. The majority of consulting rooms had level access. All patient facing areas were based on the ground floor.

The main door did not have automatic opening. However, there was a bell for patients who might need assistance with the doors to ring. There was also a bell at the main reception desk inside the practice. However, there was no bell at the lower section of the desk for wheelchair users to attract the attention of reception staff.

Patients were able to access the service in a way that was convenient for them and said they were happy with the system.

The GPs provided a personal patient list system. These lists were covered by colleagues when GPs were absent. Patients appreciated this continuity and GPs stated it helped with communication.

The GP Patient survey 2014 showed that 98 % of the respondents rated their experience of getting an appointment as convenient. This was higher than the national average. These findings were reflected during our conversations. Patients were happy with the appointment system and said they could get a same day appointment if necessary.

Information about the appointment times were found on the practice website and on notices at the practice. Patients were informed about the out of hours arrangements by a poster displayed in the practice, on the website and on the telephone answering message.

The PPG had investigated how to improve communication for patients who did not regularly attend the practice. They agreed an action plan and carried it out. This included sending a quarterly newsletter by e-mail to patients who wished to receive this and attach a paper copy to prescriptions.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Patients told us they had no complaints but knew how to make a complaint should they wish to do so.

The posters displayed in the waiting room and patient information leaflet explained how patients could make a complaint. The practice website also stated that the surgery welcomed patient opinion by sharing ideas, suggestions, views, and concerns.

The complaints procedure stated that complaints were handled and investigated by the practice manager and would initially be responded to within three days. Records were kept of complaints which showed that patients had been offered the chance to take any complaints further, for example to the parliamentary ombudsman.

Staff were able to describe what learning had taken place following a complaint. Complaints were also discussed as a standing agenda item at meetings held every month. The practice held an annual review of all complaints to ensure any learning points had been taken forward. There had been two complaints in the last 12 months.

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

The practice aims to deliver high quality care to patients but does not have a written strategy. They are planning to deal with the return of a partner GP from sickness and to replace a leaving partner. They are considering ways to reduce the stress of a day on call to reduce the risk of GP burnout. Staff at the practice focused on delivering high quality care to its patients. Staff told us that they felt well supported by the partner GPs and the practice manager.

Staff spoke positively about communication, team work and their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open, supportive culture and being a good place to work. There was a stable staff group and many staff had worked at the practice for many years and were positive about the open culture.

We were told there was mutual respect shared between staff of all grades and skills and that they appreciated the non-hierarchical approach and team work at the practice.

Staff said the practice was small enough to communicate informally through day to day events and more formally though meetings and formal staff appraisal. There was a weekly update provided to staff on any forthcoming meetings, staff rotas and other operational matters.

Governance Arrangements

Staff were familiar with the governance arrangements in place at this practice and said that systems used were both informal and formal. Issues were discussed amongst staff as they arose. GPs met daily and discussed any complex issues, workload or significant events or complaints. These were often addressed immediately and communicated through a process of face to face discussions or email. These issues were then followed up more formally at monthly clinical meetings where standing agenda items included significant events, near misses, complaints and health and safety. Staff explained these meetings were well structured, well attended and a safe place to share what had gone wrong.

The practice used the quality and outcomes framework (QOF) to assess quality of care as part of the clinical governance programme. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF scores for Mevagissey Surgery were consistently above the national average.

The practice employed a QOF co-ordinator who we spoke with during our inspection. This member of staff provides the practice with regular updates about QOF performance. The QOF co-ordinator also provided a detailed annual overview of QOF and a booklet to each member of staff to explain their roles with regard to QOF. This met best practice.

The clinical auditing system used by the GPs assisted in driving improvement. All GPs were able to share examples of audits they had performed. In addition to the incentive led audits the GPs told us they wanted to perform audits to improve the service for patients and not just for their revalidation or QOF scores. These examples included hypertension, diabetes and palliative care. We saw that audits followed a complete audit cycle. For example, a hypertension audit revealed that there were 730 patients with this condition and 564 had been checked by a GP within the last 12 months. This represented 77% of the total. This compared well with the national average which was between a range of 44-84%. The audit was repeated annually.

Data from audits was readily available to provide a resource for trainees and other staff. Audits were stored in a shared folder and presented at partners' meetings. This was recorded in meeting minutes. However, some minutes of meetings we looked at lacked clear action points and tracking of any follow up actions. There was a monthly rota which decided which GP chaired these meetings to ensure that each GP had the opportunity.

Leadership, openness and transparency

Staff were familiar with the leadership structure, which had named members of staff in lead roles. For example there was a lead nurse for infection control, a lead GP for safeguarding and a lead GP for the GP Vocational Training Scheme. Staff spoke about effective team working, clear roles and responsibilities and talked about a supportive non-hierarchical organisation. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff described an open culture within the practice and opportunities to raise issues at team meetings.

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

The practice manager was responsible for human resource policies and procedures. Staff were aware of where to find these policies if required, on paper format or online.

The leadership of the practice worked closely with their PPG and with the KCCG. This enabled the PPG to be actively involved in commissioning decisions. The PPG chair of the practice regularly attended KCCG meetings. This was an example of best practice.

Recruitment at the practice was transparent. There was a recruitment policy in place. Questions and answers given during selection interviews had been recorded in writing. A scoring system had been used to ensure openness and fairness.

Practice seeks and acts on feedback from users, public and staff

Patients we spoke with in the waiting room were aware there were suggestion boxes in the waiting room. The website signposted patients to give feedback if they chose. GP Patient Survey 2014 results showed high levels of satisfaction with the practice.

Practice management involved its staff in decision making. Significant events and recent audits were considered at practice meetings. Long term locums, salaried doctors and registrars were invited and encouraged to attend these meetings and to provide feedback.

The practice had collated results of its Friends and Family survey conducted in December 2014. Results showed of 30 respondents, 29 were very likely or likely to recommend the practice to their friends and family.

The practice had a patient participation group (PPG). The PPG member who came to the inspection said the practice manager and GPs were keen to encourage patient feedback and involvement. The PPG said they had already been consulted about improvements to the practice such as the visual display unit in the waiting room. The PPG members said they had been able to suggest additional ideas such as online booking of appointments, which were being implemented by the practice.

Management lead through learning & improvement

A process was followed so that learning and improvement could take place when events occurred or new information was provided. For example, GPs at the practice carried out peer review audits on each other every six months. These audits looked at records of a face to face consultation, a telephone consultation and a home visit. They examined details of care or treatment provided, looked at the diagnosis and checked whether anything better could have been done. GPs told us they found this process a valuable learning tool.

GPs held monthly meetings to discuss any current topics and review any newly released national guidelines and the impact for patients. There was two hours a month formal protected time set aside for continuous professional development for staff and access to further education and training as needed.

We spoke with a registrar GP who had been undergoing training at the practice for the past six months. Their overall experience had been very positive. The registrar GP stated that other GPs had been very supportive and there was a focus on learning and openness.

The practice management obtained patient views via verbal, written and PPG feedback. There was written evidence of 360 degree feedback on each of the GPs. 360 degree feedback includes comments from a member of staff's line manager, their peers and any subordinates.

The practice had systems in place to identify and manage risks to the patients, staff and visitors that attended the practice. The practice had a suitable business continuity plan to manage the risks associated with a significant disruption to the service. This included, for example, extreme weather conditions, electricity supply failure or IT loss.

There were environmental risk assessments for the building. For example, annual fire assessments, electrical equipment checks, control of substances hazardous to health (COSHH) assessments and visual checks of the building had been carried out in September 2014. Health and safety items were a standing agenda item for quarterly clinical meetings.