

Carnewater Practice

Quality Report

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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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Carnewater Practice on 10 May 2017. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems to minimise risks to patient safety. Staff were trained in safeguarding, including modern slavery.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is better than the national average of 84%.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs. We found suitable arrangements were in place which ensured the cleanliness of the practice was maintained to a high standard.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

Summary of findings

- The practice had organised and taken part in a sponsored walk for a local charity.
- The patient group had also won two awards; one for 'health promotion', which included holding a health fare in Bodmin, raising funds for a defibrillator in a remote village and organising diabetes and healthy eating awareness events. The second award was for 'changes made as a consequence of the participation group', which included parking near the practice and the purchase of new equipment.

We saw one area of outstanding practice:

The Carnewater Patient Participation Group (CPPG) were proactive in carrying out extensive research into Doctors Surgery Access and Community Transport Survey to GP services in rural areas. Their findings, the Lewannick Project, have been published. This project allowed the CPPG to inform patients living in the more rural areas of the transport available to them to attend GP appointments.

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?

The practice is rated as good for providing safe services.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Good



Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

Good



Are services caring?

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Good



Summary of findings

- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice had a policy which identified military veterans in line with the Armed Forces Covenant 2014. The policy enabled priority access to secondary care for those patients with conditions arising from service to their country.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Good



Are services well-led?

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour. In examples we reviewed we saw evidence the practice complied with these requirements.

Good



Summary of findings

- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients.

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

The practice is rated as good for the care of older people.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible
- Care Homes and paramedics had a direct-dial telephone number to the practice to help enhance access to patient information or GP advice.
- The practice provided GP input at Bodmin Hospital each day.
- Medicines were delivered to a secure collection point for patients living in rural areas.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients with diabetes, on the register, with average blood sugar levels

in the preceding 12 months was 83% which was comparable to the CCG average of 82% and the national average of 78%.

Good



Summary of findings

- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

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

- From the sample of documented examples we reviewed 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.
- Immunisation rates were relatively high for all standard childhood immunisations.

Appointments were available outside of school hours and the premises were suitable for children and babies.

- The practice held a drop-in clinic at the local college two days a week
- The practice was EEFO (EEFO is a name of a scheme in Cornwall which helps young people access health services easily) accredited to level two. They were also working towards obtaining SAVVY Kernow, a local scheme which encouraged young people to become savvy and seek help and advice about their health, wellbeing or everyday life.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working age people (including those recently retired and students).

Good



Summary of findings

- The needs of these populations 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, extended opening hours on alternate Saturday mornings
- Telephone consultations were available.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people 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.
- 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 offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- The staff were completing learning in respect of autism.
- The GPs at the practice provided a violent patient scheme for the whole of the locality.
- The practice provided shared care clinics and support for people with substance misuse and a Community Hospital Alcohol Detox service offered for the locality.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

Good



Summary of findings

- The practice carried out advance care planning for patients living with dementia.
- 100% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is better than the national average of 84%.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The percentage of patients with physical and/or mental health conditions whose notes recorded smoking status in the preceding 12 months was 95% which was the same as the national average of 95%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. 220 survey forms were distributed and 121 were returned. This represented about 1% of the practice's patient list. Results from the survey showed;

- 85% of patients described the overall experience of this GP practice as good compared with the CCG average of 90% and the national average of 85%.
- 77% of patients described their experience of making an appointment as good compared with the CCG average of 81% and the national average of 76%.
- 74% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79.5%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 29 comment cards which were all positive about the standard of care received. Seven of the cards commented on the difficulty of obtaining pre-bookable appointments. Patient's comments included staff having a caring attitude, treating patients with respect and being supportive.

We spoke with five patients during the inspection. All five patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. The practice used the NHS Friends and Family survey to obtain patient feedback. Between April 2016 to March 2017 there had been 48 respondents. Of these 37 were likely or extremely likely to recommend the practice.

Outstanding practice

The Carnewater Patient Participation Group (CPPG) were proactive in carrying out extensive research into Doctors Surgery Access and Community Transport Survey to GP services in rural areas. Their findings, the Lewannick

Project, have been published. This project allowed the CPPG to inform patients living in the more rural areas of the transport available to them to attend GP appointments.

Carnewater Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser.

Background to Carnewater Practice

The Carnewater Practice was inspected on Wednesday 10 May 2017. This was a comprehensive inspection.

The practice is situated in the town of Bodmin in Cornwall and they provide a general medical service to 11,400 patients. The practice covers a catchment area of 200 square miles of Bodmin Moor, and surrounding villages. The area spans from the outskirts of Launceston to the east, Roche in the west, Sladesbridge and St Tudy in the north, and Lerryn and Lostwithiel in the south. There is a branch surgery that opens every day in Lewannick near Launceston.

The practice's population area is in the fourth decile for deprivation, which is on a scale of one to ten. The lower the decile the more deprived an area is compared to the national average. The practice population ethnic profile is predominantly White British. The average male life expectancy for the practice area is 79 years which is the same as the national average of 79 years; female life expectancy is 82 years which is slightly lower than the national average of 83 years.

There are four GP partners, two male and two female, and three salaried GPs providing 5.7 whole time equivalents each week. The practice manager is also a partner of the practice. The partners hold managerial and financial

responsibility for running the business. The team are supported by two nurse practitioners, five practice nurses, a healthcare assistant, a phlebotomist (a person trained to take blood) and additional administration and reception staff. The practice also has a dispensary overseen by a dispensary manager.

The practice is a training and teaching practice for student nurses and GPs in training, foundation doctors and medical students.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodists and midwives who are co-located in the practice.

The practice reception is open between 8am and 6:30pm Monday to Friday. Booked appointments are offered between 8am and 6:30pm. The practice offers a range of appointment types including book on the day, telephone consultations and advance appointments. Extended hours are offered on two Saturday mornings a month between 8am and 11am. These are for pre-booked appointments only.

Outside of these times, by contractual arrangement, patients are directed to telephone the NHS 111 number for assistance.

Carnewater provided regulated activities from its main site at The Health Centre, Dennison Road, Bodmin, Cornwall PL31 2LB and the branch site at Landry House, Lewannick, PL15 7QD. During our inspection we visited the main site at Bodmin. We did not visit the branch location.

Detailed findings

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. The 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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice. We carried out an announced visit on 10 May 2017. During our visit we:

- Spoke with a range of staff including GPs, the nurse practitioner, nurses, the practice manager and administrative staff and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- Reviewed a sample of the personal care or treatment records of patients.

- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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

- 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 were provided for specific groups of people and what good care looked like for them. The population groups are:

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the samples of documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, an incident had occurred where a delay in a routine test being carried out and seen by a GP prior to a referral to a clinic resulted in the practice policies being questioned by another professional. The practice changed their policy and processes to ensure the test was carried out on the same day, the GP requesting the test reviewed the results immediately and ensured the referral to the clinic was sent urgently.
- The practice also monitored trends in significant events and evaluated any action taken.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of

staff for safeguarding. From the sample of documented examples we reviewed we found that the GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.

- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three and the nursing staff to level two.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (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).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems through audit in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken, the last in August 2016, we saw evidence that action was taken to address any improvements identified as a result.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- Two of the nurses had qualified as Independent Prescribers and could therefore prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer

Are services safe?

medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

- About 28% of the patients registered at the practice could have their prescriptions dispensed at Carnewater Surgery. Systems were in place to check that dispensary processes were suitable and the quality of the service was maintained, through audit. There was a named GP responsible for the dispensary and prescribing. The practice also, in partnership with a neighbouring practice employed a pharmacist to oversee the dispensary. Dispensary staff had completed appropriate training to work safely in the dispensary. Dispensary staff showed us standard operating procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines). Staff signed these documents and they were regularly reviewed.
- The dispensary staff used a barcode system that reduced the risk of errors when dispensing medicines. Staff recorded significant events and reported them to the practice manager. Staff received and acted upon medicines alerts. They also had a system in place that alerted the practice when patients were at risk of going into crisis through over ordering medicines.
- Patients could arrange to collect their medicines from a post office in a remote village. There were processes such as risk assessments in place to make sure that this was safe and medicines were stored appropriately and securely.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage due to their potential for misuse) and had procedures in place to manage them safely. There were also appropriate arrangements in place for the destruction of controlled drugs. Dispensary staff told us that prescriptions for controlled drugs were not dispensed before being signed by a GP. This was confirmed by a GP at the practice.
- Prescription pads were stored securely. A system was in place to monitor the use of prescription pads, and a new system for monitoring blank prescription forms used for printers was in place.

We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence

of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was an up to date health and safety policy available on the practice intranet.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises. The practice shared it's premises with another health provider and joint fire evacuation drills were carried out.
- All electrical appliances had been checked in December 2016 and the clinical equipment was checked and calibrated in August 2016 to ensure it was in effective working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment rooms.

Are services safe?

- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 97.6% of the total number of points available compared with the clinical commissioning group (CCG) average of 95.5% and national average of 95.3% with 12.5% exception reporting overall. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients were unable to attend a review meeting or certain medicines could not be prescribed because of side effects).

Data from 2015/16 showed:

- Performance for diabetes related indicators was similar to the CCG and national averages. The percentage of patients with diabetes on the register, with recorded average blood pressure readings in the last 12 months was 80% which was comparable with the CCG average of 82% and the national average of 77%.
- Performance for mental health related indicators was higher than the CCG and national averages. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive agreed care plan documented in the last 12 months was 97% which was higher than the CCG average of 92% and the national average of 89%.

The practice also recognised that the exception reporting for patients with diabetes at 20% was higher than the CCG average of 15% and the national average of 12%. We saw documentation to show the practice were reviewing these patients and they have, in conjunction with the CPPG held diabetes and healthy eating sessions. We have seen that the practice has reduced the number of excepted patients from 165 to 98 patients through frailty for example.

There was evidence of quality improvement including clinical audit:

- There had been ten clinical audits commenced in the last two years, four of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, following a significant event it was noted that a patient with a Body Mass Index (BMI) of more than 35 was taking a combined hormone contraceptive (CHC) medicine. Guidance states that before prescribing this medicine staff should take a detailed history from women requesting CHC and should recheck the history at least annually. The history should include medical conditions such as migraine, drug use, family medical history, and lifestyle factors such as smoking and (BMI) and blood pressure should be documented for all women prior to first prescription. The BMI should be less than 35. An initial audit identified that 13 patients with a BMI of more than 35 had been prescribed this medicine. Training for clinicians was provided and the practice template and contraception protocol were updated and the patients reviewed. The same search was repeated, this identified that the number had reduced to three patients who had a documented BMI of 35 or more and an ongoing prescription for CHC. These three patients were called in for an urgent medicine review.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.

Are services effective?

(for example, treatment is effective)

- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions, such as cervical screening, smoking cessation and asthma.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From the sample of documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients'

consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Monthly meetings were held with MacMillan (the cancer support organisation) and the district nurses at the practice to ensure 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.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and exercise.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/national averages. For example, rates for the vaccines given to under two year olds was 94% and five year olds was 95%. The national target for two year olds was 90% and the CCG average for five year olds was 96%.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The practice uptake for females being

Are services effective? (for example, treatment is effective)

screened for breast cancer was 77% which was the same as the CCG average of 77% and was higher than the national average of 72%. The patient uptake for bowel screening was 58%, which was comparable to the CCG average of 61% and the national average of 58%.

The practice's uptake for the cervical screening programme was 79%, which was comparable with the CCG average of 83% and the national average of 81%.

There was a policy to offer written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they

ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

All of the 29 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with six patients including four members of the Carnewater patient participation group (CPPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was comparable with CCG and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 89% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 91% of patients said the GP gave them enough time compared to the CCG average of 91% and the national average of 87%.
- 92% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 92%

- 84% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 92% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 94% and the national average of 91%.
- 93% of patients said the nurse gave them enough time compared with the CCG average of 95% and the national average of 92%.
- 96% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 99% and the national average of 97%.
- 93% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 81% of patients said they found the receptionists at the practice helpful compared with the CCG average of 90% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals. For example the practice were in the process of being approved as Savvy, replacing EEFO about being young person friendly. There was a specific noticeboard in the entrance of the practice which provided relevant information for young people. This included health promotion information on sexual health, contraception, signposting to counselling services.

Results from the national GP patient survey were in line with local and national averages. For example:

- 83% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 90% and the national average of 86%.
- 81% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.

Are services caring?

- 93% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 92% and the national average of 90%.
- 85% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.

Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 157 patients as carers (about 1.3% of the practice list). Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support. The Carnewater patient participation group (CPPG) hold a weekly support group to offer support and advice to carers. A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective.

The practice had a policy which identified military veterans in line with the Armed Forces Covenant 2014. The policy enabled priority access to secondary care for those patients with conditions arising from service to their country.

Staff told us that if families had experienced bereavement, their usual GP contacted them, this call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on alternate Saturday mornings for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.
- Other reasonable adjustments were made and action was taken to remove barriers when patients found it hard to use or access services.
- There were ramps and automatic doors leading to the entrance of the practice.
- The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for access to consultation rooms. There was enough seating for the number of patients who attended on the day of inspection.
- Accessible toilets with baby changing facilities were available for patients who attended the service.
- The Carnewater Patient Participation Group (CPPG) were proactive in carrying out extensive research into Doctors Surgery Access and Community Transport Survey to GP services in rural areas. Their findings, the Lewannick Project, have been published. This project allowed the CPPG to inform patients living in the more rural areas of the transport available to them to attend GP appointments.

Access to the service

The practice was open between 8am to 1pm and the 2.30pm to 6:30pm on a Monday and 8am to 6:30pm Tuesday to Friday. Appointments were from 8.10am to 6pm. During the lunchtime hours telephone calls were answered by another provider. Extended hours appointments were offered at the following times on alternate Saturday mornings between 8am and 11am. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for patients that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment were lower compared to local and national averages.

- 70% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 71% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 77% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 81% and the national average of 76%.
- 92% of patients said their last appointment was convenient compared with the CCG average of 95% and the national average of 92%.
- 67% of patients described their experience of making an appointment as good compared with the CCG average of 81% and the national average of 73%.
- 40.5% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 63% and the national average of 58%.

The practice has undergone staff changes within the past year with GPs retiring and a delay with new GPs starting. They were aware of their lower percentages and in addition to the increased GP numbers had begun a trial with a new appointment system that they were monitoring.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

- whether a home visit was clinically necessary; and

Are services responsive to people's needs?

(for example, to feedback?)

- the urgency of the need for medical attention.

This was done by the duty GP telephoning the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw information was available to help patients understand the complaints system. There was a poster displayed in the waiting room and information on the practice website explaining how to complain should patients wish to do so.

We looked at four of the 17 complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, showing openness and transparency in dealing with the complaint. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. For example, the practice website had been updated to ensure it gave patients the correct information.

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 had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. For example, prescribing and medicine management, information governance and clinical illnesses.
- Practice specific policies were implemented and were available to all staff on the practice intranet. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care.

They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. From the sample of seven documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Bi-weekly Monday meetings were held with a representative from all staff teams inclusive of administrative and dispensing staff. Standing agenda items were complaints and significant events.
- The GP's and nurse practitioner met informally daily to offer support to each other.
- Monthly head of department meetings were held to review the practice performance.
- Monthly full practice meetings were also held, with staff being paid overtime and luncheon was provided, to discuss all aspects of the practice.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were comprehensive and were available for practice staff to view.
- Staff told us they enjoyed working at the practice and they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in

Are services well-led?

Good 

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

discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- patients through the Carnewater patient participation group (CPPG) and through surveys and complaints received. The CPPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the group had recently undertaken a research project into how easy it was for patients to access the service. They had also influenced changes to furniture and fittings at the branch practice, and held health fairs.

- the NHS Friends and Family test, complaints and compliments received
- staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a 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. GPs at the practice were engaged with the commissioning of services in the county.