

Oak Tree Surgery

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 15 September 2015. Overall the practice is rated as good. Specifically we found the practice to be good for providing responsive, safe, effective, caring and well led services. It was also found to be good across all patient population groups (people with long-term conditions, working age people, people experiencing poor mental health (including people living with dementia), and families, children and young people.

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.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.

- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that 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.
- 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.

We saw one areas of outstanding practice :

- The practice site was RCGP (Royal College of General Practitioners) accredited as 'Research Ready'. The

Summary of findings

practice were members of the CCRG - Cornwall Clinical Research Group, formed 20 years ago and involved with all aspects of clinical research including global research studies and improving the quality of medical care. The practice undertook between eight and twelve research projects each year across a wide range of areas. Two experienced specialist research nurses, employed by the practice, together with some of the GPs at the practice created the research team. The practice felt strongly that primary care was an ideal

place to conduct clinical research and believed that this drove quality in healthcare provision and that patients would benefit from the opportunities that involvement that research provided. At the time of the inspection the practice were actively working on six projects.

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.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.

Good



Are services effective?

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as good for providing caring services.

Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

The practice had reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that 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

Good



Summary of findings

meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

The practice is rated as good for being well-led. It had a clear 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. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Patients who were living in local care homes were looked after by a named GP. Each GP had a telephone appointment booked with their homes each week to monitor ongoing care and address any concerns. Each patient had a care plan with an end of life plan and both were reviewed informally on a regular basis and more formally every six months.

The practice had a robust system in place for identifying patients who may require care plans. The administration staff created monthly lists of emergency admission patients for the lead GP who then decided which patients needed to be discussed at a Multi-Disciplinary meeting (MDT) and possible care plan required. Any emergency admissions were flagged up to the GP looking after the patient by the administration staff on a daily basis when they received the discharge summary.

Deaf and hard of hearing patients were identified by the practice and were given face to face appointments without prior telephone triage. There was a hearing loop installed in the waiting room. A board in the administration office was regularly updated with patients who needed appointments booked directly.

There was a Living Well Co-ordinator based at the Surgery and they had good links and worked very closely with the practice team. Living well is an NHS initiative which connected patients with their communities and help them access local support groups and sources of information as they require.

Other outside organisations visited the practice to provide services for patients. For example Age UK provided a weekly nail cutting service at the practice and Action for Hearing Loss attended monthly.

Good



People with long term conditions

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

Good



Summary of findings

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met; this was undertaken in the month of their birthday.

For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice had two experienced nurse practitioners who ran chronic disease clinics. Both could initiate Insulin. They held regular clinics with a diabetes specialist nurse from Derriford Hospital. The practice were taking part in a pilot scheme called GURU whereby a diabetes consultant could directly update diabetic patient records with their consultation notes through the computer system. The nurses were able also to ask questions about their diabetic patients via this route. This had improved continuity of care. The practice were also engaging in the same pilot with a cardiothoracic surgeon and the acute GP service at Derriford Hospital.

The practice had a chronic disease nurse who looked after respiratory patients and ran hypertension clinics. The practice offered 24 hour blood pressure monitoring to aid diagnosis.

The Practice nurses and health care assistants (HCA) had completed all levels of leg ulcer dressings and had good access to tissue viability specialists for support and guidance.

The practice provided enhanced services for near patient testing including in-house International Normalised Ratio monitoring (INR). This reduced the burden on hospital clinic waiting times and providing a more cost-effective and convenient service for patients in their local health communities. This had proved very popular with patients prescribed warfarin as they could be tested and received their on-going dose regime at the same appointment.

The Retinal screening service attended the practice and screened patients on a regular basis

Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place 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 A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

Good



Summary of findings

Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

There was a safeguarding lead GP who attended bi-monthly meeting with the health visitors and midwives to discuss ongoing cases and any new concerns. The lead administrator at the practice typed up the minutes from meetings and disseminated the information to all practice clinicians. All practice staff knew how and to whom to raise any safeguarding concerns. All clinical staff who saw patients on a one to one basis had Cornwall safeguarding contacts displayed in their rooms. All staff were trained in safeguarding for both adults and children according to the level of their role. The practice shared the building with health visitors so were able to discuss any safeguarding concerns immediately.

The practice offered all routine scheduled childhood immunisations including the new Meningitis vaccinations for University Students. They also offered neo-natal checks as part of an enhanced service and carried out post-natal checks.

The practice offered contraceptive device fitting and counselling and had GP with a special interest in sexual health who was also a family planning trainer.

The practice was EEFO approved. (The term EEFO does not stand for anything. EEFO is a word that has been designed by young people, to be owned by young people.) EEFO works with services in the community to make sure they are young people friendly. Once a service has been EEFO approved it means that service has met the quality standards. For example, confidentiality and consent, easy to access services, welcoming environment and staff trained on issues young people face.

The practice was involved in a service called "Tic Tac". This is a shared initiative with other practices in the area. This is where a GP and nurse from the practice provided a service at the local school offering advice and treatment to young people.

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). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. 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.

Good



Summary of findings

The practice offered the Fit for Work scheme. This was a new support service, designed to help working people who face long-term sickness absence return to work more quickly.

Extended hours were available every Wednesday so that working people could access an appointment either early in the morning or later in the evening. Telephone triage appointments were made to suit the patient. For example in the lunch time period.

The practice offered Abdominal Aortic Aneurysm (AAA) screening. This was a way of detecting a dangerous swelling (aneurysm) of the aorta. This is far more common in men aged over 65 than it is in women and younger men, so men were invited for screening in the year they turned 65.

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. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. For example the practice distributed food bank vouchers to those patients in need extra support.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff 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.

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). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice recognised that their dementia diagnosis rate was 46.73 % which was low compared to the CCG average of 61%. They worked hard to increase their diagnosis rates which included a review of all the patients in nearby care homes. In March 2015, 88

Good



Summary of findings

patients were on the dementia register this has now risen to 102. The practice had a dementia carers group who regularly held meetings at the surgery. They engaged with carers and had a carer as a member of the Patient Participation Group (PPG).

Young people with mental health issues were referred when necessary to Child and Adolescent Mental Health Services (CAMHS) locally. School nurses had an office in the practice building and had good relationships with the practice team and the communication between professionals was valued by both.

Medication re ordering for patients with dementia managed well. The practice dispensary had developed a system whereby they could identify and automatically order repeat prescriptions for dementia patients.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. For example Outlook Southwest were a counselling service and two counsellors regularly held sessions for patients at the practice.

The practice had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015. The most recent data showed the practice was performing in line with local and national averages. There were 122 responses and a response rate of 51%.

- 89.5% find it easy to get through to this surgery by phone compared with a CCG average of 81.85 and a national average of 74.4%.
- 87.6% find the receptionists at this surgery helpful compared with a CCG average of 90.9% and a national average of 86.9%.
- 96% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 89.7% and a national average of 85.4%.
- 94.3% say the last appointment they got was convenient compared with a CCG average of 94.6% and a national average of 91.8%.

- 80.4% describe their experience of making an appointment as good compared with a CCG average of 81.5% and a national average of 73.8%.
- 80.8% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 67.8% and a national average of 65.2%.
- 74.7% feel they don't normally have to wait too long to be seen compared with a CCG average of 63.5% and a national average of 57.8%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received five comment cards which were all positive about the standard of care received.

Outstanding practice

The practice site was RCGP (Royal College of General Practitioners) accredited as 'Research Ready'. The practice were members of the CCRG - Cornwall Clinical Research Group, formed 20 years ago and involved with all aspects of clinical research including global research studies and improving the quality of medical care. The practice undertook between eight and twelve research projects each year across a wide range of areas. Two experienced specialist research nurses, employed by the practice, together with some of the GPs at the practice

created the research team. The practice felt strongly that primary care was an ideal place to conduct clinical research and believed that this drove quality in healthcare provision and that patients would benefit from the opportunities that involvement that research provided. At the time of the inspection the practice were actively working on six projects. At the time of the inspection the results were not yet known as to the benefit to the patients.

Oak Tree 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 CQC pharmacist, GP specialist advisor, a nurse specialist advisor, a practice manager specialist advisor and an expert by experience. Experts by Experience are people who have experience of using care services.

Background to Oak Tree Surgery

Oak Tree Surgery was inspected on 15 September 2015. This was a comprehensive inspection.

Oak Tree Surgery provides GP primary care services to approximately 11000 people living in and around the area of Liskeard.

There are seven GP partners, five male and two female and two female salaried GPs. The practice is a training practice for Foundation Year 2 doctors and medical students.

The team were supported by a practice manager, one nurse practitioner, one lead nurse, one specialist nurse, three practice nurses, one health care assistant (HCA) and three phlebotomists. The clinical team were supported by additional reception and administration staff and the dispensary team.

The practice has a dispensary attached. A dispensing practice is where GPs are able to prescribe and dispense medicines directly to patients who live in a rural setting. Oak Tree Surgery dispensed to patients who did not have a pharmacy within a mile radius of where they lived.

Patients using the practice also had access to community nurses, midwives, community mental health teams and health visitors who visit the practice.

The practice is open on Mondays to Fridays 8.00am to 1pm and 2pm to 6pm. The practice is closed between 1-2pm. The practice was closed between 1-2pm. However, there was a message handling service available during this time and a duty GP was available to manage any emergencies.

Appointments were available Mondays to Fridays 8.30am-1pm and 2-6.00pm and on Wednesdays 7.30am-1pm and 2-8.30pm. Appointments are available Mondays to Fridays 8.30am-1pm and 2-6.00pm and on Wednesdays 7.30am-1pm and 2-8.30pm. Outside of the above opening hours the practice directed patients to the Cornwall GP Out-of-Hours service.

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.

How we carried out this inspection

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

Detailed findings

- 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
- 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)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out our announced visit on 15 September 2015. We spoke with 14 patients, five GPs, four members of the nursing team and with members of the management, reception and administration team. We also spoke with three representatives from the PPG. We collected five patient responses from our comments box which had been displayed in the waiting room. 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.

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. The practice had a significant event monitoring policy and a significant event recording form which was accessible to all staff via computer. Records and discussions with GPs identified that there was consistency in how significant events were recorded, analysed, reflected on and actions taken to improve the quality and safety of the service provided. All complaints received by the practice were entered onto the system and were treated as a significant event if necessary.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, a patient collapsed during a nurse consultation and when the emergency alarm button was pressed it failed to show in all rooms. Immediate actions were taken to address this as well as shared learning to all staff.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety. The practice used the National Reporting and Learning System (NRLS) eForm to report patient safety incidents.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and 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. The GPs

attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.

A notice was displayed in the waiting room, advising patients that nurses would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (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). One member of administration staff was trained and DBS checked for the chaperone role.

There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella.

Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

We checked how medicines were stored in the main dispensary, and found that they were stored securely and were only accessible to authorised staff. Records showed that medicines needing refrigeration were monitored and that temperature checks were carried out which ensured medication was stored at the appropriate temperature.

There were no records of room temperature monitoring kept, however the temperature was acceptable at the time of our inspection, and a cooling system was installed to ensure that medicines would always be kept at suitable

Are services safe?

temperatures. 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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Prescription forms in the dispensary were stored securely and an audit trail of the handling of these forms within the practice was maintained in line with national guidance.

The practice had established a home delivery service for some patients and had systems in place to monitor how these medicines were collected. A system had also been introduced to help some patients who found it difficult to order their repeat prescriptions. There were arrangements in place to ensure that patients were given all the relevant information they required

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.

The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current practice. Medicines were scanned using a barcode system to help reduce any dispensing errors.

The practice was signed up to the Dispensing Services Quality Scheme to help ensure processes were suitable and the quality of the service was maintained. Dispensing staff had all completed appropriate training and had their competency annually reviewed.

Recruitment checks were carried out and the six files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with 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 room. The practice had a

defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book 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 fit for use.

The practice had a comprehensive business continuity plan in place 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

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet 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 participated in the Quality and Outcomes Framework (QOF, which is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Results from 2013/2014 were 88.5% of the total number of points available, (100%). This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/2015 showed improvements showing the practice had a 99% achievement rate.

Data from 2013-2014 showed that:

- performance for diabetes assessment and care was higher than the national averages. The exception to this was a slightly lower score (77.85% compared to the national average of 88.35%) for diabetic patients having foot checks. This had since been recognised by the practice and a further member of staff trained to undertake these checks. This has improved patient care.
- the percentage of patients with hypertension having regular blood pressure tests was similar to the national average.
- 96.7% of diabetic patients had received flu vaccinations

Clinical audits were carried out to determine and demonstrate quality improvement and all relevant staff were involved to improve care, treatment and patient outcomes. There had been 15 clinical audits undertaken in the last year. For example, an audit on prescribing a particular medicine (Metformin) used for diabetes was

undertaken to ensure that patient renal function was checked regularly and was adequate for treatment. They felt it was important to identify patients who had not had recent blood tests and recall them, and in those with low Glomerular filtration rate (GFR a test used to check how well the kidneys are working), to review their treatment. The results showed 361 patients were prescribed Metformin and out of these 24 had not received a check in the past 12 months. Actions were taken to address this and all 24 were seen and blood tests undertaken.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality.

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 these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months.

Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. 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 test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan on-going care and treatment. This included when people moved between

Are services effective?

(for example, treatment is effective)

services, including when they were referred, or after they are discharged from hospital. We saw evidence that the practice held a range of meetings to discuss patients. These included structured multidisciplinary team (MDT) meetings with the mental health team, child health team, and cancer and complex care team. There were structured meetings to discuss patients who had been discharged from hospital, patients considered to be frail and those who had died.

Consent to care and treatment

Patients' consent to care and treatment was always sought 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, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through records audits to ensure it met the practice's responsibilities within legislation and followed relevant national guidance.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service. For example, a free six week course at a weight loss group.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme

was 79%, which was just slightly lower than the national average of 82%. There was a policy to offer telephone and postal reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

The practice provided enhanced services for near patient testing including in-house International Normalised Ratio monitoring (INR). This reduced the burden on hospital clinic waiting times and providing a more cost-effective and convenient service for patients in their local health communities. This had proved very popular with patients prescribed warfarin as they could be tested and received their on-going dose regime at the same appointment.

The Retinal screening service attended the practice and screened patients on a regular basis.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 92% to 95% and five year olds from 95% to 100%. Flu vaccination rates for the over 65s were 63%. These were below the CCG and national averages, however the practice were acting on this and were proactive in promoting this service and encouraging patients to have the flu vaccination.

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

The practice ran travel clinics and was a registered Yellow Fever Centre.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the five patient CQC 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 also spoke with three members of the patient participation group (PPG) on the day of our inspection. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. For example:

- 92.5% said the GP was good at listening to them compared to the CCG average of 91.7% and national average of 88.6%.
- 93.5% said the GP gave them enough time compared to the CCG average of 90.8% and national average of 86.8%.
- 99.5% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%
- 89.8% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89.5% and national average of 85.1%.

- 94.4% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93.4% and national average of 90.4%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and 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 on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were in line with local and national averages. For example:

- 95.8% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 90.4% and national average of 86.3%.
- 88.6% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 87.1% and national average of 81.5%

Staff told us that translation services were available for patients who did not have English as a first language. This included a translation link on the practice website.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. The practice held a dementia carers group who regularly held meetings at the surgery. Written information was available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them and a patient consultation was offered 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 worked with the local CCG to plan services and to improve outcomes for patients in the area. For example, The practice worked with the local clinical commissioning group (CCG) to plan services and to improve outcomes for patients in the area. For example, a more flexible appointment system was introduced to allow patients to have an appointment on the same day.

Services were planned and delivered to take into account the needs of different patient groups and to help ensure flexibility, choice and continuity of care. For example;

- The practice offered extended hours on a Wednesday early morning and late evening.
- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients / patients who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities, hearing loop and translation services available.

Access to the service

The practice was open on Mondays to Fridays 8.00am to 1pm and 2pm to 6.00pm. The practice was closed between 1-2pm. However, there was a message handling service available during this time and a duty GP was available to manage any emergencies. Appointments were available Mondays to Fridays 8.30am-1pm and 2-6.00pm and on Wednesdays 7.30am-1pm and 2-8.30pm.

There was an easy to use appointment system, which supported patient choice and enabled patients to access the right care at the right time. This was implemented in response to patient feedback as the old system was not meeting patient need. Each patient that rang for an appointment was given a telephone call back at a time convenient to them. This was on the same day if the patient felt it was urgent or could be planned days in advance if preferred. This service could also be accessed online.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages and people we spoke to on the day were able to get appointments when they needed them. For example:

- 79% of patients were satisfied with the practice's opening hours compared to the CCG average of 79.9% and national average of 75.7%.
- 89.5% patients said they could get through easily to the surgery by phone compared to the CCG average of 81.8% and national average of 74.4%.
- 80.4% patients described their experience of making an appointment as good compared to the CCG average of 81.5% and national average of 73.8%.
- 80.8% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 67.8% and national average of 65.2%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its 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 that information was available to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

The practice looked at trends and discovered that many complaints were due to patient misconception, specifically the appointments system. As a result of this they developed a "myth busters leaflet" which was based on the questions most frequently asked about the appointments system. This was also available on the website, at reception and in new patient registration packs.

The practice had received 25 complaints in the last 12 months and found these were satisfactorily handled, dealt with in a timely way with openness and transparency.

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 robust 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 in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities
- Practice specific policies were implemented and were available to all staff
- A comprehensive understanding of the performance of the practice
- A programme of continuous clinical and internal audit which is used to monitor quality and to make improvements
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions

Leadership, openness and transparency

The partners in the practice have the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty. Staff told us that regular team meetings were held. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in

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, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, one of the areas of concern was the poor flu immunisation uptake and the PPG members were exploring ways of helping the practice in getting the information more widely spread to patients. A proposed idea was to attend the local supermarket with flu leaflets and throughout the flu season be present in the waiting room and talk to patients. The PPG were had also set up a walking group for patients which met every two weeks on a Tuesday. The group had 20 – 25 members. Patients were referred by their GP if they felt this would be beneficial to them.

The practice were taking part in a pilot with Plymouth University and had a trainee nurse assigned to the PPG. The group were looking at ways of getting them involved with the 13 – 25 age groups, talking to young people about sexual health, linking older generation with young generation and health awareness.

The practice used various avenues of social media to interact with patients and keep them up to date with practice news. This included internationally recognised media sites. The PPG also produced a newsletter to keep patients updated.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example the practice was keen to work with other practices to share ideas and work collaboratively.

Are services well-led?

Good 

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

The practice was a teaching practice with a good track record and commitment to training new GPs. The practice was registered as a GP teaching and training practice for under and post graduate education.

The practice had completed reviews of significant events and other incidents and shared findings with staff both informally and formally at meetings to ensure the practice improved outcomes for patients. Records showed that regular clinical audits were carried out as part of their quality improvement process to improve the service and patient care. The results of feedback from patients, through the patient participation group, patient feedback board, family and friends test, were also used to improve the quality of services.

The practice site was RCGP (Royal College of General Practitioners) accredited as 'Research Ready'. The practice was members of the CCRG - Cornwall Clinical Research Group. This is a group of experienced GP research teams which was formed 20 years ago and was involved with all aspects of clinical research including global research studies, improving the quality of medical care. The practice undertook between eight and twelve research projects each year across a wide range of areas. Two experienced specialist Research Nurses were employed who had focussed their careers in the research field and together with some of the GPs they created the research team. The practice felt strongly that primary care was an ideal place to conduct clinical research and believed that this drove

quality in healthcare provision and that their patients would benefit from the opportunities that involvement in Research provided. At the time of the inspection the practice were actively working on six projects. Some examples of these were

- CANDID - a 20,000 patient national study which was examining GP decision making around cancer investigation and diagnosis, Oak Tree had recruited 30-40 patients and expected that this important study would increase their understanding and hopefully the quality of cancer decision making in future.
- CREDENCE - a 6,000 patient global research trial which was confirming that a class of diabetic drugs would protect the kidney from needing dialysis in future, the expectation was that this will be the first new class of drugs since the Angiotensin Converting Enzyme inhibitors / ARBs to be licenced to protect the kidney in high risk patients.
- CRYSTAL – this was another large global study comparing different classes of COPD (chronic obstructive pulmonary disease) inhaler and their effects on COPD symptom control and lung function based on regular spirometry readings. This global study should increase the evidence base in COPD management and enable clinicians to prescribe more effectively for the COPD patients in the future.